

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05317

CERTIFICATE OF DEATH

05278

Reg. Dist. No. 211

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S.</u> Last <u>Benson</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 30 - 1879</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | 9c. AGE (In years last birthday) <u>77</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 10c. AGE (In years last birthday) <u>77</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John E. Benson</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Dowden</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | |
| 17. INFORMANT <u>Mrs. Nellie Benson</u> | | Address <u>Clarksburg Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> (c) <u>10 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 17</u> , 19 <u>57</u> , to <u>May 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>57</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James P. Kerr</u> M.D. | | ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>JAMES P. KERR M.D.</u> | | DATE SIGNED <u>6/1/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/3/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville</u> | | 22d. LOCATION (City, town, or county) (State) <u>Neelsville - Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Oroya Barber</u> | | ADDRESS <u>Laytonsville</u> | |
| 24a. REC'D BY REGISTRAR <u>Della M. Burdette</u> | | 24b. REGISTRAR'S SIGNATURE <u>Della M. Burdette</u> | |

RECEIVED
JUN 9 1957
U.S. AIR FORCE

1957 9 NOV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05318

Item 7 Film 0215 5-17-57 et

CERTIFICATE OF DEATH

05279

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>11819 Drummond Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edwin BERRY</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 2 1957</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 24, 1905</u> | 9. AGE (In years last birthday) <u>52</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Charles Edwin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Edna Parmeter</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Reserve</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <u>Helen K. Berry- Item # 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444-X</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/28, 1957</u> to <u>5/2, 1957</u> , that I last saw the deceased alive on <u>5/2, 1957</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dr Joseph Kennick</u> | | | | ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md</u> | | DATE SIGNED <u>5/2/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/6/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Aspen Hill, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 5-7-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

STATE DEPARTMENT OF HEALTH—BALTIMORE 10

1957 6 MAY

RECEIVED

05319 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | c. LENGTH OF STAY IN 1b <u>4 mos. 4 days</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | d. STREET ADDRESS <u>211 Scott Drive</u> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joanne</u> Middle <u>Carol</u> Last <u>BESSETTE</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 57</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>13 Dec. 1955</u> | | 9. AGE (In years last birthday) <u>1</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | |
| 13. FATHER'S NAME <u>Alfred C. Bessette</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ella Parks</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>None</u> | | |
| 17. INFORMANT <u>(Father) Alfred C. Bessette (Same As #2)</u> | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SARCOMA BOTRYOIDES</u> <u>233x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 MONTHS</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. _____ p. m. _____ Month, Day, Year _____ | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that I attended the deceased from <u>18 Dec.</u> , 19 <u>56</u> , to <u>9 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 May 1957</u> , 19____, and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 5-10-57</u> PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-14-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Annapolis, Maryland</u> | | (State) _____ | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> | | | ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u> | | |
| 24a. REC'D BY REGISTRAR DATE <u>5-10-57</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05281

05320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 SILVER SPRING | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1019 QUEBEC TERRACE | | | | d. STREET ADDRESS 1019 QUEBEC TERRACE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ARNOLD Middle STEWART Last BLACK | | | | 4. DATE OF DEATH MAY 30 19 57 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 2, 1957 | |
| | | | | 9. AGE (In years last birthday) yrs. 1 | | IF UNDER 1 YEAR Months Days 28 | |
| | | | | | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME RONALD ALLEN BLACK | | | | 14. MOTHER'S MAIDEN NAME BEVERLY SOKOL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Ronald Allen Black, 1019 Quebec Terrace Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 475X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper Respiratory Infection DUE TO (c) INTERVIEW BETWEEN ONSET AND DEATH Found dead in bed | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) FRANK J. BROSCART | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/31/57 | | 22c. NAME OF CEMETERY OR CREMATORY National Capitol Hebrew | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Baryanovsky & Sons ADDRESS 3501 14th St., N.W. | | | | 24a. REC'D BY REGISTRAR DATE 5/31/57 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

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MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 OF 1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|----------------|--|-----------------|--|----------|--|----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | PREVIOUS DEATH | | CAUSE OF DEATH | |
| DATE OF DEATH | | PLACE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | |
| SIGNATURE OF EXAMINER | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF WITNESS | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF JURY | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF JUDGE | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF CLERK | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF SHERIFF | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF CORONER | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF JURY | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF JUDGE | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF CLERK | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF SHERIFF | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |
| SIGNATURE OF CORONER | | DATE | | PLACE | | MANNER | | DISEASE | | SYMPTOMS | |

RECEIVED
 JUN 6 1957
 BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05282

05321

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | |
|--|-------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>47X-3</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> | | |
| c. LENGTH OF STAY IN 1b <u>9 months</u> | | | d. STREET ADDRESS <u>1368 East Capitol</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4220 Brookfield Drive</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Dora</u> First <u>L</u> Middle <u>Bond</u> Last | | | 4. DATE OF DEATH <u>May 7</u> Month <u>7</u> Day <u>1957</u> Year | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 10, 1879</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Adolph Lindenbohl</u> | | | 14. MOTHER'S MAIDEN NAME <u>Pauline Prager</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>Pauline Refaratti</u> Address <u>Wash. D.C.</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> (c) <u>Generalized arterio sclerosis</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>May 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>57</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Walter K. Angevine</u> , M.D. | | | ADDRESS (Street, city or town, state) <u>6300-13th St. NW, Wash. D.C.</u> DATE SIGNED <u>5/7/57</u> | | |
| PHYSICIAN'S NAME (Type) <u>Walter K. Angevine M.D.</u> | | | 6300 13th St N.W. Washington? D C | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-10-1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> ADDRESS <u>131-11th St. NW, Wash. D.C.</u> | | | 24a. REC'D BY REGISTRAR <u>5/10/57</u> DATE | | |
| | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u> | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

MAY 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05322

05283

Reg. Dist. No. 214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>prerty</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1718 Noyes Lane</u> | | | | d. STREET ADDRESS <u>1718 Noyes Lane</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Loretta Bowden</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 13 1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-29-1872</u> | |
| 9. AGE (in years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel Brook Rushan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Charity Tenwell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <u>W.F. Rushan - Same as # 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory failure</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1/2 day</u> <u>5 1/2 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-16-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Philos Com.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westport Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Deep Funeral Home</u> | | | | ADDRESS <u>4812 Balboa Rd</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/30/57</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

DATE SIGNED
5-13-57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0232

BUREAU V. S.

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05323

CERTIFICATE OF DEATH

05284

Reg. Dist. No.

217

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Pompey Bowen | | 4. DATE OF DEATH Month Day Year May 9 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/22/1899 |
| 9. AGE (In years lost birthday) 58 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sight Seeing Guide | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Montross, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph P. Bowen | | 14. MOTHER'S MAIDEN NAME Annie V. Scates | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 577-26-3427 | |
| 17. INFORMANT Mrs. Betty Bowen, | | Address Burtonsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obesity DUE TO (c) Chronic Hypertension | | INTERVAL BETWEEN ONSET AND DEATH 4/11/57 25 yr 6 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/13 , 19 57 , to 5/9 , 19 57 , that I last saw the deceased alive on 5/6 , 19 57 , and that death occurred at 6:11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED B P Warren M.D. Fairfax Md 5/9/57 | | | |
| ACTUAL SIGNATURE B. P. WARREN | | | |
| PHYSICIAN'S NAME (Type) B. P. WARREN | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) burial | | 22b. DATE THEREOF 5/11/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | 24. REC'D BY REGISTRAR MAY 10 1957 | |
| 24b. REGISTRAR'S SIGNATURE Gertrude Lowery | | | |

CERTIFICATE OF DEATH

Form No. 100

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED <i>John V. Brown</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>May 10, 1957</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i> | |
| 10. SIGNATURE OF REGISTRAR <i>John V. Brown</i> | | 11. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i> | | 12. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 13. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 14. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 15. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 16. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 17. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 18. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 19. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 20. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 21. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 22. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 23. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 24. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 25. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 26. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 27. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 28. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 29. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 30. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 31. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 32. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 33. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 34. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 35. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 36. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 37. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 38. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 39. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 40. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 41. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 42. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 43. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 44. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 45. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
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| 52. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 53. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 54. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 55. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 56. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 57. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 58. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 59. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 60. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 61. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 62. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 63. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 64. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 65. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 66. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 67. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 68. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 69. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 70. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 71. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 72. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 73. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 74. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 75. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 76. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 77. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 78. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 79. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 80. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 81. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 82. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 83. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 84. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 85. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 86. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 87. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 88. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 89. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 90. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 91. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 92. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 93. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 94. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 95. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 96. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 97. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 98. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 99. SIGNATURE OF DECEASED <i>John V. Brown</i> | |
| 100. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 101. SIGNATURE OF DECEASED <i>John V. Brown</i> | | 102. SIGNATURE OF DECEASED <i>John V. Brown</i> | |

BUREAU V. 2

MAY 10 1957

RECEIVED

05324

CERTIFICATE OF DEATH

05285

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 4 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annadale | | | |
| d. STREET ADDRESS Route #3 Box 275 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Wade Last BOWMAN | | | | 4. DATE OF DEATH Month May Day 25 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 27 Feb. 1917 | |
| 9. AGE (In years lost birthday) 40 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical | | | | 10b. KIND OF BUSINESS OR INDUSTRY Commercial | | 11. BIRTHPLACE (State or foreign country) District of Columbia | |
| 13. FATHER'S NAME George T. BOWMAN | | | | 14. MOTHER'S MAIDEN NAME Maude WADE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT (Brother) Joseph N. Bowman (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent lobular pneumonia over 491x DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypotension (c) Increased intracranial pressure; fatty degeneration of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Increased intracranial pressure; fatty degeneration of liver INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month May Day 19 Year 1957 Hour 1:12A a. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Bethesda, Md. | | | | 20g. (County) Montgomery | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 21 May , 19 57 , to 25 May , 19 57 , that I last saw the deceased alive on 25 May , 19 57 , and that death occurred at 1:12A M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-25-57 | | | | | | | |
| ACTUAL SIGNATURE Burt C. Johnson | | | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home ADDRESS Wash. D. C. | | | | 24a. REC'D BY REGISTRAR 5-25-57 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

DECEASED

DATE OF DEATH

DECEASED

DECEASED

DATE OF DEATH

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BUREAU V. 1

MAY 29 1957

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DECEASED

05325

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|--|--|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 20 hr. 45 min. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington | | | |
| d. STREET ADDRESS 208 10th St., S.E. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Baby Middle Boy Last BRANTLEY | | 4. DATE OF DEATH | | Month May Day 13 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 May 1957 | | 9. AGE (In years lost birthday) yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 20 45 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Samuel Brantley | | | | 14. MOTHER'S MAIDEN NAME Mildred Soggon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address (Father) Samuel Brantley (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Bilateral Fetal Atelectasis (c) INTERVAL BETWEEN ONSET AND DEATH 20 3/4 hrs | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12 May , 19 57 , to 13 May , 19 57 , that I last saw the deceased alive on 13 May , 19 57 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 5-15-57 | | | | | | | |
| ACTUAL SIGNATURE John H. Mazur M.D. | | | | PHYSICIAN'S NAME (Type) John H. Mazur, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-17-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bacon Funeral Home, 1722 7th St. N.W. Wash. D.C. | | | | 24a. REC'D BY REGISTRAR DATE 5-14-57 | | 24b. REGISTRAR'S SIGNATURE May E. Russell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957 MAY 16

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05310 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05287

Reg. Dist. No. 213

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. LENGTH OF STAY IN 1b <u>2 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>304 N. Adams St.</u> | | | | d. STREET ADDRESS <u>304 N. Adams St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Eugene</u> Last <u>Breeden</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-23-1919</u> | |
| 9. AGE (In years last birthday) <u>38</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fireman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Department</u> | | 11. BIRTHPLACE (State or foreign country) <u>va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Emmet Breeden</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jane Haynes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>1949-1946</u> | | 17. INFORMANT <u>Georgia Breeden - Same as #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>5-21-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/20/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Lawell Magtry</u> | | | | | | | |

BUREAU V. S.

1957 MAY 20

RECEIVED

UNITED STATES GOVERNMENT

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05288

05311

CERTIFICATE OF DEATH

Reg. Dist. No.

213

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. LENGTH OF STAY IN 1b 42 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 Potomac Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First AMELIA Middle ALEXANDER Last BREWER | | | | 4. DATE OF DEATH Month May Day 29 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 13, 1887 | |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months 10 Days 16 Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Coleman, Texas | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Charles M. Alexander | | | | 14. MOTHER'S MAIDEN NAME Mary Brown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Husband Lloyd A. Brewer, Jr. | | Address Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative disease of spinal cord (amyotrophic lateral sclerosis) INTERVAL BETWEEN ONSET AND DEATH 9 hours 19 years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 356.1 | | | | | |
| 20c. TIME OF INJURY Month Day 19 Year 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1950 , 19 May 29 , 19 57 , that I last saw the deceased alive on May 29 , 19 57 , and that death occurred at 10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave. Bethesda, Md. DATE SIGNED 5/30/57 | | | | | | | |
| ACTUAL SIGNATURE W. A. Linthicum | | PHYSICIAN'S NAME (Type) W. A. Linthicum | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY Rockville Union Cem. | | 22d. LOCATION (City, town, or county) (State) Montgomery County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR JUN 3 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Laurel H. Hightower | | | |

UN 3 1957

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05326

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING MD</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN. REST HOME</u> | | | | d. STREET ADDRESS <u>1614 GIST AVE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS M. BRINKLEY</u> | | | | 4. DATE OF DEATH Month Day Year <u>MAY 18 1957</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 21. 1876</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>G.P. ENGRAVING.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country) <u>NOV. 21. 1876 WASHDC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>SAM. BRINKLEY.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE JOHNSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u> | | 16. SOCIAL SECURITY NO. <u>W.</u> | | 17. INFORMANT Address <u>MRS AUDREY BURRENS 614 GIST AVE.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Aortic embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>A.S.C.V.D</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 day</u> <u>years.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955</u> to <u>5/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/11/57</u> , 19 <u>57</u> , and that death occurred at <u>3P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12600 PARKLAND PR</u> DATE SIGNED <u>5/18/57</u> ACTUAL SIGNATURE <u>Charles M. Weber M.D.</u> PHYSICIAN'S NAME (Type) <u>CHARLES M WEBER M.D.</u> <u>Rockville, MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 21, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u> | | 22d. LOCATION (City, town, or county) (State) <u>WASH. D.C</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Wanner</u> | | | | ADDRESS <u>3619-14th St NW</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/20/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

| | | | | | |
|----------------------|--|--------------------------|--|--------------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | DATE OF DEATH | |
| JAMES EARL RAY | | 12-1-28 | | 5-27-68 | |
| PLACE OF BIRTH | | OCCUPATION | | CAUSE OF DEATH | |
| MOBILE, ALABAMA | | CONSTITUTIONAL | | HEART DISEASE | |
| MARRIAGE | | EDUCATION | | MANNER OF DEATH | |
| MARRIED | | HIGH SCHOOL | | NATURAL | |
| NAME OF SPOUSE | | NAME OF FATHER | | NAME OF MOTHER | |
| JANET RAY | | JAMES EARL RAY | | JANET RAY | |
| DATE OF MARRIAGE | | DATE OF BIRTH OF FATHER | | DATE OF BIRTH OF MOTHER | |
| 1950 | | 1900 | | 1900 | |
| PLACE OF MARRIAGE | | PLACE OF BIRTH OF FATHER | | PLACE OF BIRTH OF MOTHER | |
| BALTIMORE, MD | | MOBILE, ALABAMA | | MOBILE, ALABAMA | |
| OCCUPATION OF FATHER | | OCCUPATION OF MOTHER | | OCCUPATION OF DECEASED | |
| CONSTITUTIONAL | | CONSTITUTIONAL | | CONSTITUTIONAL | |
| MANNER OF DEATH | | MANNER OF DEATH | | MANNER OF DEATH | |
| NATURAL | | NATURAL | | NATURAL | |
| DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | |
| 5-27-68 | | 5-27-68 | | 5-27-68 | |
| PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | |
| BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | |
| NAME OF PHYSICIAN | | NAME OF PHYSICIAN | | NAME OF PHYSICIAN | |
| JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | |
| DATE OF EXAMINATION | | DATE OF EXAMINATION | | DATE OF EXAMINATION | |
| 5-27-68 | | 5-27-68 | | 5-27-68 | |
| PLACE OF EXAMINATION | | PLACE OF EXAMINATION | | PLACE OF EXAMINATION | |
| BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | |

BUREAU V. B.

MAY 20 1957

RECEIVED

05327 CERTIFICATE OF DEATH

05290
Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 9 hr. 45 min. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md. | | | | d. STREET ADDRESS 5133 North 37th Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last BROWNING | | | | 4. DATE OF DEATH Month May Day 27 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 26, 1957 | | 9. AGE (In years last birthday) yrs. 9 45 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Benjamin Howard BROWNING, Jr. | | | | 14. MOTHER'S MAIDEN NAME Dorothy LANEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Benjamin H. BROWNING, Jr. (Same as #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abnormal pulmonary ventilation 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Prematurity DUE TO (c) 9 1/4 hrs. | | | | INTERVAL BETWEEN ONSET AND DEATH 9 1/4 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from May 26 , 1957, to May 27 , 1957, that I last saw the deceased alive on May 27 , 1957, and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, NNMC, Bethesda, Md. 5-28-57 | | | | | | | |
| ACTUAL SIGNATURE John H. Mazur | | | | M.D. U.S. Naval Hospital, NNMC, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) John H. MAZUR LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 5-28-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

2051354XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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BUREAU V. 81

MAY 29 1957

RECEIVED

MARYLAND

05291
STATE DEPARTMENT OF HEALTH

05328 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH COUNTY <u>Mont</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Mont</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> | |
| TOWN <u>Cherry Hill</u> | | TOWN <u>Cherry Hill</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) <u>15 East Lenox</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Laura Grilstad</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1957</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>May 15 - 1865</u> | |
| 9. AGE last birthday <u>92</u> yrs. | | 10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Trendhjem Norway</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Norway</u> | |
| 13. FATHER'S NAME <u>Grilstad</u> | | 14. MOTHER'S MAIDEN NAME <u>Samstad</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Laura Bryn Winslow 15 E Lenox</u> | | 18. MEDICAL CERTIFICATION | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 Immediate cause (a) <u>Congestive Heart Disease</u> | | 10 days | |
| Antecedent cause(s) (b) <u>Coronary Thrombosis</u> | | 3 weeks | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION <u>450.0</u> | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) <u>SUICIDE</u> | | PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u> | |
| HOMICIDE | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Mar 1954</u> to <u>May 16, 1957</u> , that I last saw the deceased alive on <u>May 16, 1957</u> , and that death occurred at <u>12:35 P.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>E. Herbert Bauersfeld M.D.</u> | | ADDRESS <u>912 E St NW</u> | |
| DATE SIGNED <u>5/16/57</u> | | | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE <u>5/18/57</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | LOCATION (City, town, or county) (State) <u>Southland Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph S. Smith</u> | | ADDRESS <u>1756 Pa Ave, N.W., DC</u> | |
| DATE REC'D BY LOCAL REG <u>5-17-57</u> | | REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

BUREAU V. 21

MAY 21 1957

RECEIVED

05329

CERTIFICATE OF DEATH

Item 11 Film G216 6-19-57 et

Reg. Dist. No. 216

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Montgomery</u> | |
| CITY (If outside corporate limits, write RURAL or give nearest town) <u>Brookmont</u> | | LENGTH OF STAY (in this place) <u>1 month</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u> | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) <u>6407 McArthur Blvd.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>AGNES</u> | | (Middle) <u>J</u> | | (Last) <u>BURDETTE</u> | | (Month) <u>5</u> (Day) <u>26</u> (Year) <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>Dec 27, 1878</u> | 9. AGE last birthday <u>78</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Birmingham, England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>William B. Johnston</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ferguson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S ADDRESS <u>Mary Burdette same</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 10 month | | | |
| 154X IMMEDIATE CAUSE (A) <u>Carcinoma of the rectum</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19. DATE OF OPERATION <u>Nov 15, 1956</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the rectum</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug 1, 1956</u> , to <u>May 26, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Sred K. Sanderson</u> | | M.D. <u>1801 E. 4th St. N.W.</u> | | DATE SIGNED <u>5-26-57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5-29-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u> | | LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ching Chase Funeral Home</u> ADDRESS <u>5103 Wisconsin Ave. Wash. D.C.</u> | | | |
| DATE <u>5-29-57</u> | | | | | | | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

02322

REG. CASE NO.

AT BUREAU, RESIDENCE, HOSPITAL OR CHURCH

| | | | | | |
|---|--|--|--|---------------------------------------|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF BIRTH <i>Jan 15 1912</i> | | 5. PLACE OF BIRTH <i>St. Louis, Mo.</i> | | 6. OCCUPATION <i>Teacher</i> | |
| 7. MARITAL STATUS <i>Married</i> | | 8. COLOR <i>White</i> | | 9. RELIGION <i>Catholic</i> | |
| 10. DECEASED AT <i>Home</i> | | 11. CAUSE OF DEATH <i>Heart Disease</i> | | 12. MANNER OF DEATH <i>Natural</i> | |
| 13. DATE OF DEATH <i>Jan 25 1957</i> | | 14. TIME OF DEATH <i>10:30 AM</i> | | 15. PLACE OF DEATH <i>Home</i> | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF PHYSICIAN | |
| 19. SIGNATURE OF CLERGYPERSON | | 20. SIGNATURE OF BURIAL OFFICIAL | | 21. SIGNATURE OF REGISTRAR | |

INSTRUCTIONS
This certificate should be filled out by the physician or the person who attended the deceased. It should be filled out as soon as possible after death. It should be filled out in duplicate. One copy should be filed in the office of the Registrar of the Department of Health. The other copy should be filed in the office of the Burial Board. The certificate should be filled out in duplicate. One copy should be filed in the office of the Registrar of the Department of Health. The other copy should be filed in the office of the Burial Board.

RECEIVED
JAN 3 1957
BUREAU W.T.

05312

CERTIFICATE OF DEATH

Reg. Dist. No. 213

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. LENGTH OF STAY IN 1b 36 Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 Crabb Avenue | | | | d. STREET ADDRESS 314 Crabb Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Grant Middle BURKE Last Burk | | | | 4. DATE OF DEATH Month May Day 20 Year 19 57 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May, 15 1896 | |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months 0 Days 5 Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking Attendent | | | | 10b. KIND OF BUSINESS OR INDUSTRY Parking cars | | 11. BIRTHPLACE (State or foreign country) Tennessee | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME George Burk | | | | 14. MOTHER'S MAIDEN NAME Laurie Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I | | | | 16. SOCIAL SECURITY NO. 384-03-4055 | | 17. INFORMANT Varnie Burk, as item # 2 Address Wife | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) Congestive failure x 5 yrs | | | | INTERVAL BETWEEN ONSET AND DEATH 30 min 10 yrs 5 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) 433.1 | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 2/11/1951 , to 5/20/1957 , that I last saw the deceased alive on 5/19/1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stephen R. Jones M.D. | | | | ADDRESS (Street, city or town, state) Rockville, Md. | | DATE SIGNED 5/20/57 | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/23/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR 5/22/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Lawrence Magtong | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|---------------|--|--------------------|--|-------------------|--|-------------------|--|--------------------|--|-----------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | | 5. Time of death | | 6. Place of death | | 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | | 10. Signature of registrar | |
| John Doe | | Male | | 45 | | 1957 | | 10:00 AM | | Home | | Heart Disease | | Natural | | [Signature] | | [Signature] | |
| 11. Occupation | | 12. Education | | 13. Marital status | | 14. Date of birth | | 15. Date of death | | 16. Date of burial | | 17. Date of cremation | | 18. Date of interment | | 19. Date of removal | | 20. Date of return | |
| Teacher | | High School | | Married | | 1912 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | |
| 21. Name of informant | | 22. Address | | 23. City | | 24. State | | 25. Zip | | 26. Telephone | | 27. Name of hospital | | 28. Name of funeral home | | 29. Name of cemetery | | 30. Name of crematorium | |
| Jane Doe | | 123 Main St | | Baltimore | | MD | | 21201 | | (410) 555-1234 | | St. Mary's | | Doe & Sons | | Greenwood | | Crematorium | |

BUREAU V. 81

MAY 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05294

05330

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Arvel Canter | | | | 4. DATE OF DEATH Month Day Year May 20th 19 57 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 13, 1942 | | | |
| 9. AGE (In years last birthday) 15 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME Arvel Canter | | | | 14. MOTHER'S MAIDEN NAME Lillie Hodgson | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record The Clinical Center, Bethesda, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO (c) Acute Lymphocytic Leukemia | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 578x Loss Gastrointestinal Hemorrhage | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) 1 | | | | 20g. (County) 1 | | 20h. (State) 1 | | | |
| 21. I certify that I attended the deceased from March 12th, 1957 , to May 20th, 1957 , that I last saw the deceased alive on May 20th, 1957 , and that death occurred at 3:05P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/20/57 ACTUAL SIGNATURE Arthur J. Garceau M.D. The National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP | | 22b. DATE THEREOF 5-21-1957 | | 22c. NAME OF CEMETERY OR CREMATORY WEST-JEFFERSON | | 22d. LOCATION (City, town, or county) (State) N-C | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO | | | | ADDRESS 1400 Chapin St NW | | 24a. REC'D BY REGISTRAR 5/23/57 | | | |
| 24b. REGISTRAR'S SIGNATURE Beau Thompson | | | | | | | | | |

BUK

1957

RECEIVED

05331 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b <u>107 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> ✓ | |
| f. STREET ADDRESS <u>814 Sumerset Place, N.W.</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Grant</u> Last <u>CASKEY</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 57</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-7-1887</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy (Retired)</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Floyd W. Caskey</u> | | 14. MOTHER'S MAIDEN NAME <u>Sara Little</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Official Navy Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic carcinoma (anaplastic)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 months.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>28 Jan.</u> , 19 <u>57</u> , to <u>15 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 May</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Russell Miller, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>5-16-57</u> | | | |
| ACTUAL SIGNATURE <u>Russell Miller, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5-20-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hines Funeral Home, 2901 14th St. NW, Wash, D.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-16-57</u> | 24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|--------------------------|--|---------------------------|--|------------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 15 1912 | | BALTIMORE, MD. | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JULY 10 1935 | | BALTIMORE, MD. | | JANE HARRIS | | MAY 17 1957 | | BALTIMORE, MD. | |
| OCCUPATION | | EDUCATION | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | |
| LABORER | | 8 | | METHODIST | | HEART DISEASE | | NATURAL | | 12345 | |
| PREVIOUS ILLNESS | | DATE OF PREVIOUS ILLNESS | | PLACE OF PREVIOUS ILLNESS | | NAME OF PHYSICIAN | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | |
| NONE | | NONE | | NONE | | J. H. SMITH | | MAY 15 1957 | | BALTIMORE, MD. | |
| SIGNATURE OF DECEASED | | SIGNATURE OF SPOUSE | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | DATE OF REGISTRATION | | PLACE OF REGISTRATION | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | MAY 17 1957 | | BALTIMORE, MD. | |

BUREAU V. 8

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05296

05332

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>B. C.</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 WASHINGTON</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>LOTTIE</u> Middle <u>CHAPPEL</u> Last <u>H</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-16-00</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>US</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>John N Hopkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Lemima (unknown)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Aug. M. Chappell</u> | | Address <u>5206 1/2 River Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia due to Generalized Carcinomatosis -</u> 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of ut. ovary.</u> DUE TO (c) <u>1 month plus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 18, 1957</u> to <u>May 8, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. W. DANISH</u> | | M.D. <u>9-7 Rushing Rd. 5/8/57</u> | |
| PHYSICIAN'S NAME (Type) <u>A. W. DANISH</u> | | DATE SIGNED <u>John Rhines</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-13-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines & Company</u> | | ADDRESS <u>901 3rd St., S. W.</u> | |
| DATE <u>MAY 10 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

RECEIVED

MAY 10 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05297

Reg. Dist. No. 215

05333

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>10 hours</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California 18x22</u> | | | | d. STREET ADDRESS <u>7 Gables Road</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Laverne</u> Last <u>CLARKE</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-28-49</u> | |
| 9. AGE (In years last birthday) <u>7</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> | | IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1957</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Thomas T. Clarke</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gaynell I. Kelly</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT (Father) <u>Thomas T. Clarke (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis, Bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction of trachea and left main bronchus by mucus plug</u> (c) <u>Hemorrhage and contusion of brain</u> <u>Depressed skull fracture</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child running after ball into street, struck by automobile</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5:00</u> p.m. <u>4-30</u> 19 <u>57</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> | | 20f. (City or town) (County) (State) <u>California</u> <u>Maryland</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Dr. Frank J. Broschart, MD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-3-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robinson Funeral Home, Leonardtown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-1-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>May L. Parrelly</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME(5)
5M 9/55

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02331

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

RECEIVED
MAY 6 1957
BUREAU V. 3

05334

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenmont</u> | | | | c. LENGTH OF STAY in 1b <u>7 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>15212 Nahant St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>JOLLIFFE</u> Last <u>CLARKSON</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 2, 1914</u> | |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MANAGER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE DEPT</u> | | 11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>HUGH THOMPSON CLARKSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY JOLLIFFE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR 2</u> | | | | 16. SOCIAL SECURITY NO. <u>578-07-9784</u> | | 17. INFORMANT <u>AGNES CLARKSON</u> Address <u>5212 NAHANT ST.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> <u>162x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 MOS.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>JULY 1956</u> , 19____, to <u>MAY 9, 1957</u> , that I last saw the deceased alive on <u>MAY 9, 1957</u> , 19____, and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2540 Pa. Ave. N.W. WASH. D.C.</u> DATE SIGNED <u>MAY 9, 1957</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Paul H. Taylor M.D.</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>PAUL H. TAYLOR M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/13/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawlis Sons</u> ADDRESS <u>1756 Pa. Ave. N.W. DC</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-11-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. 3.

13 1957

RECEIVED

05335 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights 16X2.2 ✓ | | | |
| d. STREET ADDRESS 5204 28th Parkway | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Bash Last CLEGG | | | | 4. DATE OF DEATH Month May Day 29 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 15, 1881 | | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower | | 10b. KIND OF BUSINESS OR INDUSTRY Commercial | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Matthew CLEGG | | | | 14. MOTHER'S MAIDEN NAME Adaline BASH | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 163-24-5725 | | 17. INFORMANT Mrs. Edward Rohrer 308 Claiborne Towers, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 21, 1957 , to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 8:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Robert C. Thomas M.D. U.S. Naval Hospital, Bethesda, Md. 5-29-57 PHYSICIAN'S NAME (Type) Robert C. THOMAS, M.D. U.S. Naval Hospital, Bethesda, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-4-57 | | 22c. NAME OF CEMETERY OR CREMATORY homewood Private Cemetery | | 22d. LOCATION (City, town, or county) (State) Wilkinsburg, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Funeral Home, Good Hope Road, Anacostia | | | | 24a. REC'D BY REGISTRAR DATE 5-29-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 19

DEPARTMENT OF HEALTH - BALTIMORE 19

DEPARTMENT OF HEALTH - BALTIMORE 19

DEPARTMENT OF HEALTH - BALTIMORE 19

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DEPARTMENT OF HEALTH - BALTIMORE 19

DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. I.

ON 3 1957

RECEIVED

05336

CERTIFICATE OF DEATH

05300
216

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 153 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church | | | | d. STREET ADDRESS 515 Graham Road | | | |
| 3. NAME OF DECEASED (Type or print) First Thelma Middle Alegre Last Climenhaga | | | | 4. DATE OF DEATH Month May Day 29 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2 December 1917 | |
| 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min. | | IF UNDER 24 HRS. Months 39 Days 39 Hours 39 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unascertainable | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Lengford Van Horn | | | | 14. MOTHER'S MAIDEN NAME Sarah Lowther | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 577-18-6236 | | 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, Right upper lobe, LUNG DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA TO BRAIN, LIVER, AND BONES DUE TO (c) BRAIN, LIVER, AND BONES INTERVAL BETWEEN ONSET AND DEATH 10 Mo. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from December 27, 1956 , to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED 5/29/57 | | | | | | | |
| ACTUAL SIGNATURE Gurston Goldin | | | | M.D. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) Gurston Goldin, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek | | 22d. LOCATION (City, town, or county) (State) Washington DC | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home | | | | ADDRESS 4812 Ga Ave NW, Wash, DC | | 24a. REC'D BY REGISTRAR 4 1957 | |
| 24b. REGISTRAR'S SIGNATURE Beane Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 4 1957

RECEIVED

05289

CERTIFICATE OF DEATH

0530173

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Maryland | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. LENGTH OF STAY IN 1b 2 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Ronald Middle Burton Last Conley | | | | 4. DATE OF DEATH Month May Day 8 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-10-91 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY West Virginia | | 11. BIRTHPLACE (State or foreign country) America | |
| 13. FATHER'S NAME Thomas Conley | | | | 14. MOTHER'S MAIDEN NAME Sarah Manear | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-07-5840 | | | |
| 17. INFORMANT Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/6/57 , 19____, to 5/8/57 , 19____, that I last saw the deceased alive on 5/8/57 , 19____, and that death occurred at 1145 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Raymond Q. West M.D. | | | | PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 5/13/57 | | Moreland Mem. | | Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Brooks Bradley Inc. | | | | ADDRESS Dundalk, Md. | | 24a. REC'D BY REGISTRAR J. Nelson | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE J. Nelson | |

MAY 10 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

05337 CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. LENGTH OF STAY IN 1b <u>5 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Maudella</u> Middle <u>Rebecca</u> Last <u>Cooper</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/6/98</u> | |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u> | |
| 13. FATHER'S NAME <u>Charles Watson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Janie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hospital Record</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Hypertension</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5/24</u> , 19 <u>57</u> , to <u>5/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>5/3/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/6/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant,</u> | | 22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u> | | | | ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>MAY 7 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Gertie L. Lacey</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 10

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | |
| 3. AGE [Faint text] | | 4. RACE [Faint text] | |
| 5. DATE OF BIRTH [Faint text] | | 6. PLACE OF BIRTH [Faint text] | |
| 7. DATE OF DEATH [Faint text] | | 8. PLACE OF DEATH [Faint text] | |
| 9. CAUSE OF DEATH [Faint text] | | 10. MANNER OF DEATH [Faint text] | |
| 11. SIGNATURE OF PHYSICIAN [Faint text] | | 12. SIGNATURE OF REGISTRAR [Faint text] | |
| 13. SIGNATURE OF WITNESS [Faint text] | | 14. SIGNATURE OF DECEASED [Faint text] | |
| 15. SIGNATURE OF NEXT OF KIN [Faint text] | | 16. SIGNATURE OF BURIAL OFFICIAL [Faint text] | |
| 17. SIGNATURE OF CHURCH OFFICIAL [Faint text] | | 18. SIGNATURE OF FUNERAL HOME [Faint text] | |
| 19. SIGNATURE OF CEMETERY OFFICIAL [Faint text] | | 20. SIGNATURE OF INTERVIEWER [Faint text] | |
| 21. SIGNATURE OF INTERVIEWER [Faint text] | | 22. SIGNATURE OF INTERVIEWER [Faint text] | |
| 23. SIGNATURE OF INTERVIEWER [Faint text] | | 24. SIGNATURE OF INTERVIEWER [Faint text] | |
| 25. SIGNATURE OF INTERVIEWER [Faint text] | | 26. SIGNATURE OF INTERVIEWER [Faint text] | |
| 27. SIGNATURE OF INTERVIEWER [Faint text] | | 28. SIGNATURE OF INTERVIEWER [Faint text] | |
| 29. SIGNATURE OF INTERVIEWER [Faint text] | | 30. SIGNATURE OF INTERVIEWER [Faint text] | |
| 31. SIGNATURE OF INTERVIEWER [Faint text] | | 32. SIGNATURE OF INTERVIEWER [Faint text] | |
| 33. SIGNATURE OF INTERVIEWER [Faint text] | | 34. SIGNATURE OF INTERVIEWER [Faint text] | |
| 35. SIGNATURE OF INTERVIEWER [Faint text] | | 36. SIGNATURE OF INTERVIEWER [Faint text] | |
| 37. SIGNATURE OF INTERVIEWER [Faint text] | | 38. SIGNATURE OF INTERVIEWER [Faint text] | |
| 39. SIGNATURE OF INTERVIEWER [Faint text] | | 40. SIGNATURE OF INTERVIEWER [Faint text] | |
| 41. SIGNATURE OF INTERVIEWER [Faint text] | | 42. SIGNATURE OF INTERVIEWER [Faint text] | |
| 43. SIGNATURE OF INTERVIEWER [Faint text] | | 44. SIGNATURE OF INTERVIEWER [Faint text] | |
| 45. SIGNATURE OF INTERVIEWER [Faint text] | | 46. SIGNATURE OF INTERVIEWER [Faint text] | |
| 47. SIGNATURE OF INTERVIEWER [Faint text] | | 48. SIGNATURE OF INTERVIEWER [Faint text] | |
| 49. SIGNATURE OF INTERVIEWER [Faint text] | | 50. SIGNATURE OF INTERVIEWER [Faint text] | |
| 51. SIGNATURE OF INTERVIEWER [Faint text] | | 52. SIGNATURE OF INTERVIEWER [Faint text] | |
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RECEIVED
 MAY 7 1957
 BUREAU V. I.
 17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05338

CERTIFICATE OF DEATH

05303 216
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 56 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville | | | |
| 3. NAME OF DECEASED (Type or print) First Susan Middle Irene Last WARD Cooper | | | | 4. DATE OF DEATH Month May Day 26 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 28, 1917 | |
| 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Rodney Charles Ward | | | | 14. MOTHER'S MAIDEN NAME Susan Palmer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 132-07-5369 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC & Renal Failure 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Insufficiency (c) Rheumatic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 10 months May year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 31 , 19 57 , to May 26 , 19 57 , that I last saw the deceased alive on May 26 , 19 57 , and that death occurred at 7:05 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/26/57 ACTUAL SIGNATURE Richard J. Sanders M.D. National Institutes of Health PHYSICIAN'S NAME (Type) RICHARD J. SANDERS, M. D. Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 5-31-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State) Southland Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co | | | | 24a. REC'D BY REGISTRAR 29 1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>1900-01-01</i></p> | | <p>4. Date of death: <i>1957-05-29</i></p> | |
| <p>5. Place of birth: <i>New York</i></p> | | <p>6. Place of death: <i>New York</i></p> | |
| <p>7. Cause of death: <i>Heart disease</i></p> | | <p>8. Manner of death: <i>Natural</i></p> | |
| <p>9. Signature of physician: <i>John Doe</i></p> | | <p>10. Signature of registrar: <i>John Doe</i></p> | |

BUREAU V. 41

MAY 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05290

CERTIFICATE OF DEATH

05304

Reg. Dist. No. 223

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 700 Hudson Avenue | | | | d. STREET ADDRESS 120 Hesketh Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) ANNIE First | | Middle L. | | Last COSTELLO | | 4. DATE OF DEATH May 22, 19 57 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 22, 1870 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Patrick G. Nash | | | | 14. MOTHER'S MAIDEN NAME Annie Hughes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address Walter J. Costello, (Same as # 2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Acute dilatation left ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Hypertensive arteriosclerotic Heart Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis, Chronic Pulmonary Emphysema, General Arteriosclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 332 X | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 47 to May 22, 19 57 , that I last saw the deceased alive on May 20, 19 57 , and that death occurred at M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William J. Collins | | | | ADDRESS (Street, city or town, state) 1150 Jamiesont St NW Washington, DC | | | |
| PHYSICIAN'S NAME (Type) | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/24/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | 22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Lewis, Inc. | | | | ADDRESS 1756 Pa. Ave., N.W. | | 24a. REC'D BY REGISTRAR 3/24/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. William Nash | | | |

05339

CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>GAITHERSBURG</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> | | | | c. LENGTH OF STAY IN 1b <u>21 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ASBURY METHODIST HOME</u> | | | | d. STREET ADDRESS <u>NONE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>L</u> Last <u>CREEEL</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1957</u> | | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>WH</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 5 1975</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>LUCELIA F CREEEL</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>EDDIE H. CREEEL</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>LUCELIA F. CREEEL</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | 17. INFORMANT Address <u>ASBURY METHODIST HOME, GAITHERSBURG, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>diabetes</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>One month</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>10-24</u> , 19 <u>56</u> , to <u>5-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Sarah E. Glover</u> | | | | ADDRESS (Street, city or town, state) <u>4308 Anthony St. Newington, Md</u> | | | |
| DATE SIGNED <u>5-29-57</u> | | | | M.D. <u>5-29-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Sarah E. Glover</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-31-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Marshall Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Marshall. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR <u>May 31-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles L. Cooke</u> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|----------------------------|--|----------------------------|--|
| 1. PLACE OF DEATH | | 2. SEX | |
| 3. AGE | | 4. RACE | |
| 5. OCCUPATION | | 6. MARITAL STATUS | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | |
| 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | |
| 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |

| | | | |
|----------------------------|--|----------------------------|--|
| 13. PLACE OF BIRTH | | 14. DATE OF BIRTH | |
| 15. PLACE OF DEATH | | 16. DATE OF DEATH | |
| 17. CAUSE OF DEATH | | 18. MANNER OF DEATH | |
| 19. SIGNATURE OF PHYSICIAN | | 20. SIGNATURE OF REGISTRAR | |

| | | | |
|----------------------------|--|----------------------------|--|
| 21. PLACE OF BIRTH | | 22. DATE OF BIRTH | |
| 23. PLACE OF DEATH | | 24. DATE OF DEATH | |
| 25. CAUSE OF DEATH | | 26. MANNER OF DEATH | |
| 27. SIGNATURE OF PHYSICIAN | | 28. SIGNATURE OF REGISTRAR | |

RECEIVED

BUREAU V. S.

JUN 5 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, See: Birth Cert. et

05291

CERTIFICATE OF DEATH

05306223
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN lb <i>11 hours 44 min</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium and Hospital</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i> d. STREET ADDRESS <i>1801 Newton, N. W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Infant Girl</i> First Middle Last <i>Davis</i> | | 4. DATE OF DEATH Month Day Year <i>May 4, 1957</i> | |
| 5. SEX <i>Girl</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 3, 1957</i> |
| 9. AGE (In year last birthday) yrs. Months Days Hours Min. <i>11 44</i> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Don Elroy Davis</i> | | 14. MOTHER'S MAIDEN NAME <i>Loretta Daisy R Ryder</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO (b) <i>Premature delivery</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 3, 1957</i> , to <i>May 4, 1957</i> , that I last saw the deceased alive on <i>May 4, 1957</i> , and that death occurred at <i>2:00 a. m.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>H. H. Diamond</i> | | DATE SIGNED <i>5/4/57</i> | |
| PHYSICIAN'S NAME (Type) <i>H. H. DIAMOND</i> | | M.D. <i>8224-ga ave</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>5-4-57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Washington San. & Hosp.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Takoma Park, Montg. Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. ...</i> | | ADDRESS <i>Washington San. & Hospital</i> | |
| 24a. REC'D BY REGISTRAR <i>MAY 6 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>William Dodd</i> | |

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05292 Item 2. See: Birth Cert. et
CERTIFICATE OF DEATH

05307

Reg. Dist. No. **223**

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>6 hours 4 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>1801 Newton, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Infant Girl</u> First Middle Last 5. SEX <u>Girl</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 3, 1957</u> 9. AGE (In years last birthday) <u>3</u> 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> 11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>4</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>Don Elroy Davis</u> 14. MOTHER'S MAIDEN NAME <u>Loretta Daisy Ryder</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Mother</u> 17. INFORMANT <u>Mother</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>In complete pregnancy</u> DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) | | | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 3, 1957</u> , to <u>May 3, 1957</u> , that I last saw the deceased alive on <u>May 3, 1957</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE <u>H. H. Diamond</u> ADDRESS (Street, city or town, state) <u>8224-ga ave S Md</u> DATE SIGNED <u>5/3/57</u> | | | | PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | 22b. DATE THEREOF <u>5-5-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Montg. Md.</u> | | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fox MD</u> ADDRESS <u>Washington San. & Hosp.</u> | | | | 24a. REC'D BY REGISTRAR <u>MAY 6 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>William D. ...</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

Page One of

BUREAU V. B.

MAY 7 1957

RECEIVED

05293

CERTIFICATE OF DEATH

05308

Reg. Dist. No. 223

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THACMA PA. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16152 HYATTSVILLE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. + Hosp. Tol | | d. STREET ADDRESS M13 EAST-WEST HWY. | |
| 3. NAME OF DECEASED (Type or print) DELLINGER Last First Middle | | 4. DATE OF DEATH MAY 8 1957 Last Month Day Year | |
| 5. SEX K. | 6. COLOR OR RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/27/57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. 12 Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME GARLAND DELLINGER | | 14. MOTHER'S MAIDEN NAME ALICE LEO LA MILLER. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. MOTHER | |
| 17. INFORMANT MOTHER | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.2 Congenital malformation of heart (Interventricular septal defect) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 757.3 Congenital malformation of right kidney (hydronephrosis) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year May 19 1957 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/27 , 19 57 , to 5/8 , 19 57 , that I last saw the deceased alive on 5/8 , 19 57 , and that death occurred at 9:20 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph J. McDonald M.D. | | ADDRESS (Street, city or town, state) Repp Road Hyattsville, Md | |
| DATE SIGNED 5/8/57 | | | |
| PHYSICIAN'S NAME (Type) JOSEPH J. McDONALD, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Transit Burial | May 10, 1957 | Fishers Hill Cemetery | Fishers Hill, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters | | ADDRESS 254 Canal Drive N.C. | |
| 24a. REC'D BY REGISTRAR 5/8/57 | | 24b. REGISTRAR'S SIGNATURE J. Arthur Walters | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

05309

Reg. Dist. No. 215

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>1 Day</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Brooks</u> Middle <u>Sheppard</u> Last <u>DENT</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>13 Aug. 1887</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Richard Dent</u> | | 14. MOTHER'S MAIDEN NAME <u>Amelia Belle Smith</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 9-9-10 to 8-30-26</u> | |
| 16. SOCIAL SECURITY NO. <u>578-12-3660</u> | | 17. INFORMANT <u>Bertie H. Smith, Brooke, Virginia</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>± Adams-Stokes Syndrome</u> DUE TO (c) <u>+ Acute Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>9 May</u> , 19 <u>57</u> , to <u>9 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 May</u> , 19 <u>57</u> , and that death occurred at <u>11:40 P</u> M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <u>Henry B. Karpinski</u> M.D. | | U.S. Naval Hospital, Bethesda, Md. | | 5-11-57 | | PHYSICIAN'S NAME (Type) <u>Henry B. Karpinski, LT, MC, USN</u> U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-14-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>5-10-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u> | |

CERTIFICATE OF DEATH

| | | | |
|---------------------------|--|---------------------------|--|
| PLACE OF DEATH | | MARRIAGE | |
| A. CITY OR TOWN | | B. COUNTY | |
| C. STATE | | D. ZIP CODE | |
| E. HUSBAND'S NAME | | F. WIFE'S NAME | |
| G. DATE OF DEATH | | H. TIME OF DEATH | |
| I. PLACE OF BIRTH | | J. DATE OF BIRTH | |
| K. SEX | | L. RACE | |
| M. OCCUPATION | | N. CAUSE OF DEATH | |
| O. MEDICAL HISTORY | | P. PRESENT ILLNESS | |
| Q. SIGNATURE OF DECEASED | | R. SIGNATURE OF WITNESS | |
| S. SIGNATURE OF PHYSICIAN | | T. SIGNATURE OF CORONER | |
| U. SIGNATURE OF JUDGE | | V. SIGNATURE OF CLERK | |
| W. SIGNATURE OF NOTARY | | X. SIGNATURE OF REGISTRAR | |
| Y. SIGNATURE OF VENDOR | | Z. SIGNATURE OF OTHER | |

BUREAU V. 8

MAY 14 1957

RECEIVED

05341

CERTIFICATE OF DEATH

Reg. Dist. No. 215.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>1 Hr. 40 min.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church 83X-3</u> | | | |
| d. STREET ADDRESS <u>108 Greenwood Drive</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Martha</u> Last <u>DICKSON</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10 Dec. 1955</u> | |
| 9. AGE (In years last birthday) <u>1</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Alfred Richard Dickson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Krumm</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>(Father) Alfred R. Dickson (Same As #2)</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Circulatory Collapse</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypernatremic Brain Damage</u> DUE TO (c) <u>Gastro enteritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>8 hours</u> <u>3 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>10 May</u> , 19 <u>57</u> , to <u>10 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 May</u> , 19 <u>57</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John H. Mazur</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 5-11-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>John H. Mazur, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>14 MAY 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Pearson's Funeral Home</u> | | | | ADDRESS <u>427 N Wash Falls Church Va.</u> | | 24a. REC'D BY REGISTRAR <u>Mary E. Parrelly</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 15 1957

RECEIVED

| 05342 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 05311 | |
|---|--|---------------------------------------|--|---|--|--|--|---|--|---|--|
| Item 21: G216 5-31-57L | | | | | | | | | | CERTIFICATE OF DEATH | |
| Reg. Dist. No. 216 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | | c. LENGTH OF STAY IN 1b 42 days | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | d. STREET ADDRESS Box 94 | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Deborah Middle Jean Last Dorsey | | | 4. DATE OF DEATH Month May Day 15 Year 19 57 | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 12, 1956 | | 9. AGE (In years last birthday) yrs. 1 | | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Asa Dorsey | | | | | | 14. MOTHER'S MAIDEN NAME Betty Simms | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymph Leukemia T GS + GV Hematopo 204.0 DUE TO Klebsiella Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) E-Coli Septicemia (c) 2 weeks INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 53.3 | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 3, 1957 , to May 15, 1957 , that I last saw the deceased alive on May 15, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE Richard D Fritz | | | | M.D. The Clinical Center | | | | DATE SIGNED 5/15/57 | | | |
| PHYSICIAN'S NAME (Type) Richard D. Fritz, M.D. | | | | National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5-17-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Fairview | | | | 22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | | | | | ADDRESS Winfield, Maryland | | 24a. REC'D BY REGISTRAR DATE MAY 17 '57 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

BUREAU V. E.

MAY 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05312

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville (rural) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital | | | | d. STREET ADDRESS RFD # 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ralph Middle Dorsey Last | | | | 4. DATE OF DEATH Month May Day 31 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/13/1905 | |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Howard Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jam es W. Dorsey | | | | 14. MOTHER'S MAIDEN NAME Louisa Hopkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Lily An derson ,Glenwood,Howard Co.,M d. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | May 31, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY Bush Park, | | 22d. LOCATION (City, town, or county) (State) Cookesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR JUN 6 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--------------------------------------|--|--------------------------------------|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | | AGE [Faint text] | |
| DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | | PLACE OF DEATH [Faint text] | |
| OCCASION OF DEATH [Faint text] | | CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| SIGNATURE OF MEDICAL EXAMINER [Faint text] | | SIGNATURE OF WITNESS [Faint text] | | SIGNATURE OF CORONER [Faint text] | |
| CITY OF BALTIMORE [Faint text] | | COUNTY OF BALTIMORE [Faint text] | | STATE OF MARYLAND [Faint text] | |

RECEIVED
 JUN 6 1957
 BUREAU V. S.

BALTIMORE, MD.
 JUNE 6, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05313

05344

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | c. LENGTH OF STAY IN 1b 20 yrs. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9405 WORTH AVENUE | | | | d. STREET ADDRESS 1 9405 WORTH AVENUE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ELLA Middle FRANCES Last DOVE | | | | 4. DATE OF DEATH Month MAY Day 26 Year 19 57 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUGUST 10, 1880 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76 | | IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME RICHARD H. W. REED | | | | 14. MOTHER'S MAIDEN NAME ELLA F. HEPBURN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mr. George W. Dove, 9405 Worth Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 20 YRS. | | | | INTERVAL BETWEEN ONSET AND DEATH 3 WKS. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from OCTOBER, 1954 , to MAY 26, 1957 , that I last saw the deceased alive on MAY 26, 1957 , and that death occurred at 4²⁰ P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James R. Coleman MD | | | | ADDRESS (Street, city or town, state) 113 CARROLL ST NW WASHINGTON 12 D.C. | | | |
| PHYSICIAN'S NAME (Type) JAMES R. COLEMAN | | | | DATE SIGNED 5/26/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 5/31/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Francis J. Latta | | | |

RECEIVED

05345

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>Montgomery</i> | MARYLAND | STATE <i>md</i> | COUNTY <i>Montgomery</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Silver Spring</i> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Silver Spring</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) <i>10117 Kemross Rd.</i> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH: | |
| (First) <i>CHRISTINA</i> | (Middle) <i>DRAEGER</i> | (Last) | (Month) (Day) (Year) <i>May 7 1957</i> |
| 5. SEX: <i>Female</i> | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: <i>Dec 8, 1872</i> |
| 9. AGE last birthday: <i>84</i> yrs | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country): <i>md</i> | | 12. CITIZEN OF WHAT COUNTRY: <i>USA</i> | |
| 13. FATHER'S NAME: <i>Dietrich Draeger</i> | | 14. MOTHER'S MAIDEN NAME: <i>Maria C. Mensing</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS: <i>Gertrude Rowley 10117 Kemross Rd.</i> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) <i>442.X</i> <i>Terminal Bronchial pneumonia</i> | | | <i>2 days</i> |
| ANTECEDENT CAUSE (S) (B) <i>Cardio-Vascular Renal Disease</i> | | | <i>5 yrs.</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Arterio-sclerosis</i> | | | <i>10 yrs.</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <i>450.0</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>4/15, 1957</i> to <i>5/7, 1957</i> , that I last saw the deceased alive on <i>5/6, 1957</i> , and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above. | | | |
| 23. SIGNATURE OF REGISTRAR: <i>Francis W. Dickerson</i> | | DATE SIGNED: <i>5/7/57</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF: <i>May 9, 1957</i> | |
| NAME OF CEMETERY OR CREMATORY: <i>Nash Creek</i> | | LOCATION (City, town, or county) (State): <i>Washington D.C.</i> | |
| DATE REC'D BY LOCAL REGISTRAR: <i>5/13/57</i> | | 24. FUNERAL DIRECTOR ADDRESS: <i>James Potter Real Funeral Home 4812 So. Con. Ave.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAY 21 1957

RECEIVED

05346

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 15 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Russell Middle Alton Last Dudderar | | | | 4. DATE OF DEATH Month May Day 4 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 17, 1892 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 4 Days 19 Hours 57 | | IF UNDER 24 HRS. Months 4 Days 19 Hours 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Director (Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Dr. D. Alton Dudderar | | | | 14. MOTHER'S MAIDEN NAME Myra L. Ecker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI | | | | 16. SOCIAL SECURITY NO. 359-03-6484 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anuria & uremia, Bronchopneumonia 201X DUE TO Massive Gastro-Intestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease - abdominal DUE TO (c) also - Left Subclinal Hemorrhage | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X Arteriosclerosis - severe | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 19 , 19 57 , to May 4 , 19 57 , that I last saw the deceased alive on May 4 , 19 57 , and that death occurred at 1:30 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-4-57 | | | | | | | |
| ACTUAL SIGNATURE Chester Z. Haverback M.D. | | | | NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) Chester Z. Haverback, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 7-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery | | 22d. LOCATION (City, town, or county) (State) Unionville- Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son W. | | | | ADDRESS Frederick-Maryland | | 24a. REC'D BY REGISTRAR DATE 7 May 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

07553

MAY 8 1957

RECEIVED

BUREAU V. 3

05347

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney md</u> | | c. LENGTH OF STAY IN 1b <u>20 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY CHILDS</u> First Middle Last | | 4. DATE OF DEATH <u>MAY</u> Month Day Year <u>23</u> <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG 28 1875</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William Childs</u> | | 14. MOTHER'S MAIDEN NAME <u>Octavia Owen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>2</u> | |
| 17. INFORMANT <u>Elmer R Duley</u> Address <u>Deerwood md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases chest</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1 yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>3/1/57</u> , 19 <u>57</u> , to <u>5/23/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/23/57</u> , 19 <u>57</u> , and that death occurred at <u>1</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>5/23/57</u> | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | M.D. <u>[Signature]</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>May 26</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u> | 22d. LOCATION (City, town, or county) (State) <u>Olney md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u> ADDRESS <u>Laytonville, md</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/28/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05294

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington, D.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u> | | | | d. STREET ADDRESS <u>712-19th St. N.W.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle (Last) <u>Mrs. Linche (Emphanion)</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Chinese</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/15/05</u> | |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> Hours <u>19</u> Min. <u>59</u> | | IF UNDER 24 HRS. Months <u>5</u> Days <u>29</u> Hours <u>19</u> Min. <u>59</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>China</u> | | 11. BIRTHPLACE (State or foreign country) <u>China</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>China</u> | |
| 13. FATHER'S NAME <u>Swang Lee</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mamee Lim</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Daughter</u> | | Address <u>Wash., D.C.</u> | |
| | | | | <u>712-19th St. N.W.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>Thyroid storm postop thyroidectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>422.1</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>57</u> , to <u>May 29</u> 19 <u>57</u> that I last saw the deceased alive on <u>May 29</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city or town, state) <u>1414 Underwood St. N.W. D.C.</u> | | | |
| DATE SIGNED <u>5/29/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>C. ALLEN WALL</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>June 1, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | | | ADDRESS <u>234 Canale St. N.W. S.W. 12 D.C.</u> | | 24. REC'D BY REGISTRAR <u>[Signature]</u> | |
| | | | | DATE <u>JUN 9 - 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO. 100

| | | | | | | | | | | | |
|--|--|----------------------------------|--|---------------------------------|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED [REDACTED] | | 2. SEX [REDACTED] | | 3. AGE [REDACTED] | | 4. DATE OF BIRTH [REDACTED] | | 5. PLACE OF BIRTH [REDACTED] | | 6. OCCUPATION [REDACTED] | |
| 7. MARITAL STATUS [REDACTED] | | 8. COLOR [REDACTED] | | 9. RELIGION [REDACTED] | | 10. EDUCATION [REDACTED] | | 11. SOCIAL SECURITY NUMBER [REDACTED] | | 12. MANNER OF DEATH [REDACTED] | |
| 13. CAUSE OF DEATH [REDACTED] | | 14. PLACE OF DEATH [REDACTED] | | 15. TIME OF DEATH [REDACTED] | | 16. SIGNATURE OF DECEASED [REDACTED] | | 17. SIGNATURE OF WITNESS [REDACTED] | | 18. SIGNATURE OF PHYSICIAN [REDACTED] | |
| 19. SIGNATURE OF REGISTRAR [REDACTED] | | 20. DATE OF DEATH [REDACTED] | | 21. TIME OF DEATH [REDACTED] | | 22. PLACE OF DEATH [REDACTED] | | 23. MANNER OF DEATH [REDACTED] | | 24. CAUSE OF DEATH [REDACTED] | |

BUREAU V. S.

JUN 10 1957

RECEIVED

05348

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|---|---------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>171200 Takoma Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE <u>Brooke Grove Foundation</u> | | | | d. STREET ADDRESS <u>11200 Prospect Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William W Eastman</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>32</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 11-1866</u> | | 9. AGE (In years last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>11</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASTER RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SD ADVENTIST</u> | | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Nathanial A Eastman</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>ALMIRA ANN Fairchild</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u></u> | | | | 17. INFORMANT Address <u>W. W. Eastman, M.D. (Same as #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dry Gangrene left leg + Toxemia</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Far advanced art. Sclerosis Gen</u> DUE TO <u>15 yrs</u> (c) <u>Senility + Debility</u> DUE TO <u>20 yrs</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 May</u> , 19 <u>57</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>May 31</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. B. ZIEGLER</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 4, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM</u> | | 22d. LOCATION (City, town, or county) (State) <u>RIGGS RD, HYATTSVILLE, PG Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Ziegler</u> ADDRESS <u>12 DC 254 GARRISON</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 5/24/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawler</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

1957

RECEIVED

so was
for

1957
1957
1957

05349

CERTIFICATE OF DEATH

Reg. Dist. No. 211

| | | | | | | | |
|--|----------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield | | | | c. LENGTH OF STAY IN 1b 3 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Gaithersburg | | | | d. STREET ADDRESS / R.F.D. Gaithersburg | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle I. Last Fallon | | | | 4. DATE OF DEATH Month May Day 24 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 6, 1872 | | 9. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Straw Hat Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John C. Fallon | | | | 14. MOTHER'S MAIDEN NAME Josephine Fallon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-05-90614 | | 17. INFORMANT Mr. Wm. J. Mathers, Gaithersburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroseptal cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 20, 1957 to May 29, 1957 , that I last saw the deceased alive on May 21, 1957 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Damascus, Md. | | | | DATE SIGNED May 24-57 | | | |
| ACTUAL SIGNATURE James P. Kerr | | | | M.D. Damascus, Md. | | | |
| PHYSICIAN'S NAME (Type) James P. Kerr, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 27, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John L. Moberg | | | | ADDRESS Damascus, Md. | | 24a. REC'D BY REGISTRAR DATE May 25, 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE William H. Burdette | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

18325

REG. DIV. NO. 211

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|---------------------|--|-----------------------|--|------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | M | | 45 | | 1912 | | BALTIMORE | | MD | | USA | | | |
| OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | |
| LABORER | | HEART DISEASE | | NATURAL | | MAY 27 1957 | | BALTIMORE | | MD | | USA | | | |
| FAMILY PHYSICIAN | | CORONER | | BURIAL | | DATE OF BURIAL | | PLACE OF BURIAL | | CITY | | STATE | | COUNTRY | |
| DR. J. H. HARRIS | | J. H. HARRIS | | BALTIMORE | | MAY 27 1957 | | BALTIMORE | | MD | | USA | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF BURIAL | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

BUREAU V. S.

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05295 CERTIFICATE OF DEATH

06466

Reg. Dist. No. 223

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY IN 1b <i>2 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hosp.</i> | | | | d. STREET ADDRESS <i>1709-Dennis Ave.</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Eugene</i> Middle <i>George</i> Last <i>Fasenmyer</i> | | | | 4. DATE OF DEATH Month <i>May</i> Day <i>26</i> Year <i>1957</i> | | | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10-27-87</i> | |
| 9. AGE (In years last birthday) <i>69</i> yrs. | | IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> | | IF UNDER 24 HRS. Hours <i></i> Min. <i></i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Weigh master</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>State Grain Dept.</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>Penn.</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>Amer. U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Anthony Fasenmyer</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Sterner</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>487-09-5842</i> | | | |
| 17. INFORMANT <i>Washington San & Hosp. Records</i> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis</i> DUE TO (c) <i>Hypertensive cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs</i> <i>72 hrs</i> <i>years</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>443X</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 24, 1957</i> to <i>May 25, 1957</i> , that I last saw the deceased alive on <i>May 25, 1957</i> , and that death occurred at <i>9:15 AM</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Philip C. Jones</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive, Silver Spring, Md.</i> | | | |
| DATE SIGNED <i>5-26-57</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>PHILIP E. JONES</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>5/29/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>ST. JOHN'S CEMETERY</i> | | 22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i> ADDRESS <i>SILVER SPRING, MD.</i> | | | | 24a. REC'D BY REGISTRAR <i>JUN 9 - 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>William D. ...</i> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

BUREAU V. 2

JUN 10 1957

RECEIVED

05350

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 122 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS Philadelphia, Pennsylvania | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Vashti | | First Dorthea | | Middle Fauntroy | | Lost | |
| 4. DATE OF DEATH May | | Month 8, | | Day 1957 | | Year | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 24, 1911 | |
| 9. AGE (In years last birthday) 46 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME David S. Hooper | | | | 14. MOTHER'S MAIDEN NAME Lena Ford | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 125-16-6326 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 195X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic adrenal carcinoma DUE TO (c) yes. INTERVAL BETWEEN ONSET AND DEATH yes. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from January 6, 1957 , to May 8, 1957 , that I last saw the deceased alive on May 8, 1957 , and that death occurred at 10:05 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center | | | | DATE SIGNED 5/9/57 | | | |
| ACTUAL SIGNATURE Sherman Weissman M.D. | | | | National Institutes of Health Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) Sherman Weissman, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-15-57 | | 22c. NAME OF CEMETERY OR CREMATORY Eden Cemetery | | 22d. LOCATION (City, town, or county) (State) Darby, Delaware Co., Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. | | | | ADDRESS 901 3rd St., S. W. | | 24a. REC'D BY REGISTRAR DATE 6/13/57 | |
| 24b. REGISTRAR'S SIGNATURE Mary L. Lattelle Bessie Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

MAY 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05298

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05320

Reg. Dist. No. 123

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>20 yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Sheridan Ave</u> | | d. STREET ADDRESS <u>103 Sheridan Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Feltman</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-14-1886</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>War Dept</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wm Feltman</u> | | 14. MOTHER'S MAIDEN NAME <u>Robina Beattie</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>527.1</u> | |
| 17. INFORMANT <u>Mrs Ethel Feltman</u> | | Address <u>103 Sheridan Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary emphysema</u> 527.1 DUE TO (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>15 yr</u> | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>5-22-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/25/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> | | ADDRESS <u>2901 14th St., N.W.</u> | |
| 24a. REC'D BY REGISTRAR <u>5/23/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u> | |

STATEMENT OF HEALTH - BALTIMORE, MD MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|-----------------------------------|--|---|--|------------------------------|--|-----------------------------|--|---------------------------------|--|
| 1. FULL NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF DEATH | |
| 6. PLACE OF DEATH | | 7. CITY OR TOWN | | 8. COUNTY | | 9. STATE | | 10. ZIP CODE | |
| 11. OCCUPATION | | 12. CAUSE OF DEATH | | 13. MANNER OF DEATH | | 14. TIME OF DEATH | | 15. SIGNATURE OF EXAMINER | |
| 16. SIGNATURE OF NEXT OF KIN | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF JURY | | 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF DEPUTY CORONER | |
| 21. SIGNATURE OF MEDICAL EXAMINER | | 22. SIGNATURE OF ASSISTANT MEDICAL EXAMINER | | 23. SIGNATURE OF NURSE | | 24. SIGNATURE OF CHAPLAIN | | 25. SIGNATURE OF CLERGY | |
| 26. SIGNATURE OF SOCIAL WORKER | | 27. SIGNATURE OF VOLUNTEER | | 28. SIGNATURE OF INTERPRETER | | 29. SIGNATURE OF TRANSLATOR | | 30. SIGNATURE OF OTHER | |

BUREAU V. 2

MAY 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05321

05351

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alta Vista</u> | | c. LENGTH OF STAY IN 1b <u>Alta Vista</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5525 Charles Street</u> | | d. STREET ADDRESS <u>5525 Charles Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>L.</u> Last <u>Foster</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 5, 1864</u> |
| 9. AGE (In years last birthday) <u>92</u> | | IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Charles Clinton</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances A. Ireland</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs John A. Dickinson- Item# 2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>50</u> , to <u>May 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>57</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>George Sharpe</u> M.D. PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>5/14/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-14-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

AY 16 1957

RECEIVED

05352

CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>germantown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>germantown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u> | | d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Idella</u> First <u>Frize</u> Last | | 4. DATE OF DEATH <u>May-13-</u> Month <u>13-</u> Day <u>1957</u> Year | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb-6-1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home-keeping at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gaithersburg, Md</u> | 9. AGE (In years last birthday) <u>73</u> yrs. <u>3</u> Months <u>10</u> Days <u></u> Hours <u></u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>George Reed</u> | | 14. MOTHER'S MAIDEN NAME <u>Leiby</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Mary E. Donaldson, 1927 C Place S.E. D.C.</u> | |
| 17. INFORMANT <u>Mary E. Donaldson, 1927 C Place S.E. D.C.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct-10-</u> , 19 <u>45</u> , to <u>May-13-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May-13-</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7-Brooks Ave</u> DATE SIGNED <u>W. C. Miller</u> ACTUAL SIGNATURE <u>W. C. Miller, M.D.</u> M.D. <u>Gaithersburg, Md.</u> PHYSICIAN'S NAME (Type) <u>W. C. Miller, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5-16-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garton, Gaithersburg, Md</u> ADDRESS <u>Gaithersburg, Md</u> | | 24a. REC'D BY REGISTRAR <u>Abdul J. Cook</u> DATE <u>May 16, 57</u> | 24b. REGISTRAR'S SIGNATURE <u>Abdul J. Cook</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| Name of Deceased <i>William E. Miller</i> | | Date of Death <i>May 13 - 1937</i> | |
| Age <i>78</i> | | Sex <i>Male</i> | |
| Race <i>White</i> | | Marital Status <i>Married</i> | |
| Place of Birth <i>St. Louis, Mo.</i> | | Usual Residence <i>1200 E. Madison St., Baltimore, Md.</i> | |
| Cause of Death <i>Heart Failure</i> | | Immediate Cause <i>Myocardial Infarction</i> | |
| Contributing Cause <i>Arteriosclerosis</i> | | Occupation <i>Retired</i> | |
| Signature of Physician <i>W. C. Miller, M.D.</i> | | Signature of Registrar <i>W. C. Miller</i> | |
| Date of Signature <i>May 13 - 1937</i> | | Date of Registration <i>May 13 - 1937</i> | |

RECEIVED
MAY 29 1937
BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|----------------------------------|--|---|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 216 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 6622 Braeburn Parkway | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon d. STREET ADDRESS Route #2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Stanley Middle Richard Last GARDNER | | 4. DATE OF DEATH Month May Day 6 Year 19 57 | | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1892 June 26, 1882 | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months 10 Days 10 | IF UNDER 24 HRS. Hours 10 Min. 10 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Self-Employed | | 11. BIRTHPLACE (State or foreign country) London, England | | 12. CITIZEN OF WHAT COUNTRY? USA (Nat.) | | | |
| 13. FATHER'S NAME Charles Gardner | | | 14. MOTHER'S MAIDEN NAME Emily Jane Unknown | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Fred Gardner -- Item # 2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous attacks | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED May 6, 1957 | | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/9/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arnon Cemetery | | 22d. LOCATION (City, town, or county) (State) Forestville Fairfax Va. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS #7557 Wis. Ave. Bethesda, Md | | 24a. REC'D BY REGISTRAR 5-7-57 | | 24b. REGISTRAR'S SIGNATURE James M. Thompson | |

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History of previous attacks

BUREAU V. 1

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16x02 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | d. STREET ADDRESS 5600 - 16th Avenue, Apt. # 2 | | | |
| 3. NAME OF DECEASED (Type or print) Infant Boy Geer | | | | 4. DATE OF DEATH May 6, 1957 | | | |
| 5. SEX Boy | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 6, 1957 | |
| 9. AGE (In years last birthday) 2 | | 10. UNDER 1 YEAR 2 | | 11. UNDER 24 HRS. 5 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Howard Stark Geer, Jr. | | | | 14. MOTHER'S MAIDEN NAME Charmion Paulette Cheanault | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | | |
| 17. INFORMANT | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure to Establish Respiration 759.0 DUE TO Probable - Tracheal Stenosis/Atresia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity, Web Neck, Malformed Ears - Clubfoot - Rt. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 6, 1957 to May 6, 1957 that I last saw the deceased alive on May 6, 1957 , and that death occurred at 12:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ralph Steller | | | | ADDRESS (Street, city or town, state) 931 Pershing Dr. - S.S. | | | |
| PHYSICIAN'S NAME (Type) Ralph Steller, M.D. | | | | DATE SIGNED 5/11/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Cremation | | 5-9-57 | | Washington Sanitarium & Hosp, Takoma Park, Montg. Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. [unclear] | | | | ADDRESS Wash. San. & Hospital | | | |
| 24a. REC'D BY REGISTRAR 5/11/57 | | | | 24b. REGISTRAR'S SIGNATURE J. William Dodd | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | |
| 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | |
| 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | |
| 7. MARITAL STATUS [Faint text] | | 8. CAUSE OF DEATH [Faint text] | |
| 9. MEDICAL HISTORY [Faint text] | | 10. SIGNATURE OF DECEASED [Faint text] | |
| 11. SIGNATURE OF WITNESS [Faint text] | | 12. SIGNATURE OF DECEASED [Faint text] | |
| 13. SIGNATURE OF WITNESS [Faint text] | | 14. SIGNATURE OF DECEASED [Faint text] | |
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| 99. SIGNATURE OF WITNESS [Faint text] | | 100. SIGNATURE OF DECEASED [Faint text] | |

BUREAU V. B.

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05355 CERTIFICATE OF DEATH

05325

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY North | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12009 Milton Street | | d. STREET ADDRESS 12009 Milton Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle George Last Georyopoulos | | 4. DATE OF DEATH Month May Day 27 Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 15, 1892 |
| 9. AGE (In years lost birthday) 64 yrs. | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist | | 10b. KIND OF BUSINESS OR INDUSTRY Florist | |
| 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? Greece | |
| 13. FATHER'S NAME George Georyopoulos | | 14. MOTHER'S MAIDEN NAME Pagona Economos | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 577-48-1463 | |
| 17. INFORMANT wife | | Address Anna Georyopoulos 12009 Milton St. SS, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February , 1957, to May 27 , 1957, that I last saw the deceased alive on Feb 15 , 1957, and that death occurred at 3:00 A.M. , from the causes and at the date stated above. | | | |
| ACTUAL SIGNATURE Michael A. O'Shady | | M.D. 10620 Levee over, Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, or other disposition burial | | 22b. DATE THEREOF 5/29/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | 24. REG'D BY REGISTRAR MAY 28 1957 | |
| 24b. REGISTRAR'S SIGNATURE Frances Toller | | | |

RECEIVED

MAY 28 1967

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

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|---|--|---|--|--|--|
| 1. NAME OF DECEASED John J. Jones | | 2. SEX Male | | 3. AGE 65 | |
| 4. DATE OF DEATH May 15, 1967 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH Home | |
| 7. CAUSE OF DEATH Heart Disease | | 8. MANNER OF DEATH Natural | | 9. SIGNATURE OF PHYSICIAN J. H. Smith | |
| 10. SIGNATURE OF DECEASED John J. Jones | | 11. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 12. SIGNATURE OF REGISTRAR J. H. Smith | |
| 13. SIGNATURE OF DECEASED John J. Jones | | 14. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 15. SIGNATURE OF REGISTRAR J. H. Smith | |
| 16. SIGNATURE OF DECEASED John J. Jones | | 17. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 18. SIGNATURE OF REGISTRAR J. H. Smith | |
| 19. SIGNATURE OF DECEASED John J. Jones | | 20. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 21. SIGNATURE OF REGISTRAR J. H. Smith | |
| 22. SIGNATURE OF DECEASED John J. Jones | | 23. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 24. SIGNATURE OF REGISTRAR J. H. Smith | |
| 25. SIGNATURE OF DECEASED John J. Jones | | 26. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 27. SIGNATURE OF REGISTRAR J. H. Smith | |
| 28. SIGNATURE OF DECEASED John J. Jones | | 29. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 30. SIGNATURE OF REGISTRAR J. H. Smith | |
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| 34. SIGNATURE OF DECEASED John J. Jones | | 35. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 36. SIGNATURE OF REGISTRAR J. H. Smith | |
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| 97. SIGNATURE OF DECEASED John J. Jones | | 98. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 99. SIGNATURE OF REGISTRAR J. H. Smith | |
| 100. SIGNATURE OF DECEASED John J. Jones | | 101. SIGNATURE OF WITNESSES J. H. Smith, J. D. Brown | | 102. SIGNATURE OF REGISTRAR J. H. Smith | |

05297 CERTIFICATE OF DEATH

Reg. Dist. No.

773

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|--|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. LENGTH OF STAY IN 1b 11 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Reuben Middle A (int. only) Last Goldstein | | | | 4. DATE OF DEATH Month May Day 9 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-15-85 | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months 24 Days 11 Hours 11 Min. | IF UNDER 24 HRS. Months 24 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired. | | 11. BIRTHPLACE (State or foreign country) Poland | | |
| 13. FATHER'S NAME Jacob Goldstein | | | 14. MOTHER'S MAIDEN NAME Devera (unknown) | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease (c) Hypertensive Cardiovascular Renal Disease INTERVAL BETWEEN ONSET AND DEATH 24 hours at least 4 years Unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442X | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from Jan 9 , 19 53 , to May 9 , 19 57 , that I last saw the deceased alive on May 8 , 19 57 , and that death occurred at 6:18 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Clara H. Traumm | | | ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring Md | | DATE SIGNED May 9, 1957 | | |
| PHYSICIAN'S NAME (Type) Jack Lewis | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF 5-10-57 | 22c. NAME OF CEMETERY OR CREMATORY Myra Israel | 22d. LOCATION (City, town, or county) | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis | | | 24. REC'D BY REGISTRAR May 10 1957 | 25. REGISTRAR'S SIGNATURE J. H. H. H. H. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

FILE NO.

| | | | |
|---|--|--|--|
| <p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. RACE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. DATE OF DEATH</p> <p>7. PLACE OF DEATH</p> <p>8. CAUSE OF DEATH</p> <p>9. MANNER OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF WITNESS</p> <p>12. SIGNATURE OF DECEASED</p> | | <p>13. NAME OF REGISTRAR</p> <p>14. NAME OF WITNESS</p> <p>15. NAME OF DECEASED</p> <p>16. NAME OF DECEASED</p> <p>17. NAME OF DECEASED</p> <p>18. NAME OF DECEASED</p> <p>19. NAME OF DECEASED</p> <p>20. NAME OF DECEASED</p> <p>21. NAME OF DECEASED</p> <p>22. NAME OF DECEASED</p> <p>23. NAME OF DECEASED</p> <p>24. NAME OF DECEASED</p> <p>25. NAME OF DECEASED</p> <p>26. NAME OF DECEASED</p> <p>27. NAME OF DECEASED</p> <p>28. NAME OF DECEASED</p> <p>29. NAME OF DECEASED</p> <p>30. NAME OF DECEASED</p> <p>31. NAME OF DECEASED</p> <p>32. NAME OF DECEASED</p> <p>33. NAME OF DECEASED</p> <p>34. NAME OF DECEASED</p> <p>35. NAME OF DECEASED</p> <p>36. NAME OF DECEASED</p> <p>37. NAME OF DECEASED</p> <p>38. NAME OF DECEASED</p> <p>39. NAME OF DECEASED</p> <p>40. NAME OF DECEASED</p> <p>41. NAME OF DECEASED</p> <p>42. NAME OF DECEASED</p> <p>43. NAME OF DECEASED</p> <p>44. NAME OF DECEASED</p> <p>45. NAME OF DECEASED</p> <p>46. NAME OF DECEASED</p> <p>47. NAME OF DECEASED</p> <p>48. NAME OF DECEASED</p> <p>49. NAME OF DECEASED</p> <p>50. NAME OF DECEASED</p> <p>51. NAME OF DECEASED</p> <p>52. NAME OF DECEASED</p> <p>53. NAME OF DECEASED</p> <p>54. NAME OF DECEASED</p> <p>55. NAME OF DECEASED</p> <p>56. NAME OF DECEASED</p> <p>57. NAME OF DECEASED</p> <p>58. NAME OF DECEASED</p> <p>59. NAME OF DECEASED</p> <p>60. NAME OF DECEASED</p> <p>61. NAME OF DECEASED</p> <p>62. NAME OF DECEASED</p> <p>63. NAME OF DECEASED</p> <p>64. NAME OF DECEASED</p> <p>65. NAME OF DECEASED</p> <p>66. NAME OF DECEASED</p> <p>67. NAME OF DECEASED</p> <p>68. NAME OF DECEASED</p> <p>69. NAME OF DECEASED</p> <p>70. NAME OF DECEASED</p> <p>71. NAME OF DECEASED</p> <p>72. NAME OF DECEASED</p> <p>73. NAME OF DECEASED</p> <p>74. NAME OF DECEASED</p> <p>75. NAME OF DECEASED</p> <p>76. NAME OF DECEASED</p> <p>77. NAME OF DECEASED</p> <p>78. NAME OF DECEASED</p> <p>79. NAME OF DECEASED</p> <p>80. NAME OF DECEASED</p> <p>81. NAME OF DECEASED</p> <p>82. NAME OF DECEASED</p> <p>83. NAME OF DECEASED</p> <p>84. NAME OF DECEASED</p> <p>85. NAME OF DECEASED</p> <p>86. NAME OF DECEASED</p> <p>87. NAME OF DECEASED</p> <p>88. NAME OF DECEASED</p> <p>89. NAME OF DECEASED</p> <p>90. NAME OF DECEASED</p> <p>91. NAME OF DECEASED</p> <p>92. NAME OF DECEASED</p> <p>93. NAME OF DECEASED</p> <p>94. NAME OF DECEASED</p> <p>95. NAME OF DECEASED</p> <p>96. NAME OF DECEASED</p> <p>97. NAME OF DECEASED</p> <p>98. NAME OF DECEASED</p> <p>99. NAME OF DECEASED</p> <p>100. NAME OF DECEASED</p> | |
|---|--|--|--|

BUREAU V. S.

MAY 10 1957

RECEIVED

05356 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Fairborn | |
| c. LENGTH OF STAY IN 1b 51 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 72X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 120 James Drive | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Evelyn Middle Mary Last Gundlach | | 4. DATE OF DEATH Month May Day 1 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 18, 1911 |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Sessions | | 14. MOTHER'S MAIDEN NAME Mary Carlin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unascertainable | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of stomach = metastases to abd. tissues, + 151X DUE TO cervical nodes. Congested (R) foot secondary to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive venous occlusion DUE TO multiple pulmonary infarcts (c) multiple renal infarcts | | INTERVAL BETWEEN ONSET AND DEATH 3 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 11 , 19 57 , to May 1 , 19 57 , that I last saw the deceased alive on May 1 , 19 57 , and that death occurred at 2:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Peter D. Olch | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) Peter D. Olch, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur.-Transit | 22b. DATE THEREOF 4/2/57 | 22c. NAME OF CEMETERY OR CREMATORY St. Josephs | 22d. LOCATION (City, town, or county) (State) Newark, Ohio |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 5-3-57 | |
| | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAY 6 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, See: Birth Cert. et

05357 CERTIFICATE OF DEATH

05328

Reg. Dist. No. 215

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY in lb <u>5 Hr. 50 min.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u> d. STREET ADDRESS <u>1523 Rosedale St., N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>HAMILTON</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 57</u> | | | | | |
| 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1 May 1957</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours <u>5</u> Min. <u>50</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>George Hamilton</u> 14. MOTHER'S MAIDEN NAME <u>Evelyn Blanche Brent</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates at service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT (Mother) <u>Mrs. Evelyn B. Hamilton (Same As #2)</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis & Anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>1 May</u> , 19 <u>57</u> , to <u>1 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 May</u> , 19 <u>57</u> , and that death occurred at <u>5:25 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John H. Mazur</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 5-2-57</u> PHYSICIAN'S NAME (Type) <u>John H. Mazur, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-7-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) _____ | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bacon</u> ADDRESS <u>Bacon Funeral Home, 1722 7th St., N.W. Wash. D.C.</u> | | | | | |
| 24a. REC'D BY REGISTRAR <u>Mary E. Parrelly</u> | | 24b. REGISTRAR'S SIGNATURE _____ | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051275 XVI

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05358

CERTIFICATE OF DEATH

05329

Reg. Dist. No. 214

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | c. LENGTH OF STAY IN 1b 6 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clement Lane, Springbrook Forest | | d. STREET ADDRESS Clement Lane, Springbrook Forest | |
| 3. NAME OF DECEASED (Type or print) Edward E. Hansler | | 4. DATE OF DEATH May 18 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 10, 1875 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Meat Dealer | |
| 11. BIRTHPLACE (State or foreign country) New York, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Hansler | | 14. MOTHER'S MAIDEN NAME Catherine Dear | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Wesley S. Meginn, Clement Lane, Silver Spring | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Cancer of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 9 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Generalized Arteriosclerosis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 5, 1954 to May 18, 1957 that I last saw the deceased alive on May 18, 1957 and that death occurred at 4 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John J. Curry | | ADDRESS (Street, city or town, state) 10620 Geogin Ave Silver Spring, Md | |
| PHYSICIAN'S NAME (Type) John J. Curry | | DATE SIGNED 5/21/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 21, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 22d. LOCATION (City, town, or county) (State) Orange County, New York |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS Silver Spring, Md. | |
| 24a. REC'D BY REGISTRAR DATE 5/21/57 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED [Illegible] | | 2. SEX [Illegible] | | 3. AGE [Illegible] | | 4. RACE [Illegible] | |
| 5. PLACE OF BIRTH [Illegible] | | 6. DATE OF BIRTH [Illegible] | | 7. PLACE OF DEATH [Illegible] | | 8. DATE OF DEATH [Illegible] | |
| 9. OCCUPATION [Illegible] | | 10. CAUSE OF DEATH [Illegible] | | 11. MANNER OF DEATH [Illegible] | | 12. SIGNATURE OF PHYSICIAN [Illegible] | |
| 13. SIGNATURE OF REGISTRAR [Illegible] | | 14. SIGNATURE OF WITNESS [Illegible] | | 15. SIGNATURE OF WITNESS [Illegible] | | 16. SIGNATURE OF WITNESS [Illegible] | |

BUREAU V. 4

1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05359

CERTIFICATE OF DEATH

05330

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bronx 69x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 909 Sheridan Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Rose Middle (None) Last Harbanoff | | | | 4. DATE OF DEATH Month May Day 1 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 22, 1909 | |
| 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR Months 1 Days 19 Hours 57 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) New York | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Abraham Harbanoff | | | | 14. MOTHER'S MAIDEN NAME Sophie Shatkin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 110-03-4881 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmic and cardiac arrest DUE TO 410x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Combined aortic and mitral regurgitation DUE TO 17 hrs. (c) Calcific aortic and mitral stenosis 43 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 21 , 19 57 , to May 1 , 19 57 , that I last saw the deceased alive on May 1 , 19 57 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE R. Robinson Baker M.D. | | | | DATE SIGNED 5/1/57 | | | |
| PHYSICIAN'S NAME (Type) R. Robinson Baker, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/2-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baron de Hirsch Cem. | | 22d. LOCATION (City, town, or county) (State) Staten Island NY | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home 4217 9th St NW | | | | 24a. REC'D BY REGISTRAR DATE 5-6-57 | | 24b. REGISTRAR'S SIGNATURE Baron de Hirsch Cem. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-30

CERTIFICATE OF DEATH

100-30

BUREAU V. 3

MAY 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05331

05360 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | d. STREET ADDRESS 1 | |
| 3. NAME OF DECEASED (Type or print) JOSEPHINE First HARDING Middle HARDING Last | | 4. DATE OF DEATH Month May Day 25 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 30, 1869 |
| 9. AGE (In years lost birthday) 88 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Elizabeth Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Ethel Martin, Cabin Johns, Md. (granddaughter) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abdominal carcinomatosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, Cachexia | | INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. 19 p. m. Month, Day, Year | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 December 1946 to 25 May, 1957 , that I last saw the deceased alive on 25 May, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boyd, Maryland DATE SIGNED 27 May 57 | | | |
| ACTUAL SIGNATURE John G. Fawcett M.D. | | DATE SIGNED 27 May 57 | |
| PHYSICIAN'S NAME (Type) John G. Fawcett | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/30/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Brownstown | | 22d. LOCATION (City, town, or county) (State) Germantown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Burdette | | ADDRESS Rockville, Md. | |
| 24a. REC'D BY REGISTRAR JUN 3 1957 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

05361

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md. x2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | | | d. STREET ADDRESS <u>2611-PARKER AVE.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY, M. HARTMAN</u> | | | | 4. DATE OF DEATH <u>MAY 23 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN 10 - 89</u> | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penn. Philadelphia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>George Cunliffe</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>MRS Gladys Rudolph (Daughter)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>2 hrs.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>NOV</u> , 19 <u>56</u> , to <u>23 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Morris Perry</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>11602 Georgie Ave Silver Spring Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5/27/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FERNWOOD CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>UPPER DARBY, PENNSYLVANIA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner S. Karpfing</u> | | | | ADDRESS <u>8454 Sa An</u> | | 24a. REC'D BY REGISTRAR <u>DATE 5-28-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u> | | | |

10

1844

BUREAU V. S.

MAY 31 1957

RECEIVED

05362

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS #5 Tulip Avenue | |
| 3. NAME OF DECEASED (Type or print) First Everett Middle West Last Hawkins | | 4. DATE OF DEATH Month May Day 1 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 1, 1888 |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during all of working life, even if retired) General Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Government | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Hawkins | | 14. MOTHER'S MAIDEN NAME Julia Pope | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Pneumonia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 19, 1957 , to May 1, 1957 , that I last saw the deceased alive on May 1, 1957 , and that death occurred at 2:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED James R. Jude ACTUAL SIGNATURE James R. Jude M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) James R. Jude, M.D. | | | |
| 22a. BURIAL/CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF MAY 4 1957 | 22c. NAME OF CEMETERY OR CREMATORY BROOK GROVE Park Lawn | 22d. LOCATION (City, town, or county) (State) Montgomery & D. R. M. Co. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. BARBER LAYTONSVILLE MD | | 24a. REC'D BY REGISTRAR DATE 5-7-57 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 9 1957

BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05363

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05334

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|--|--|------------------------|
| 1. PLACE OF DEATH a. STREET ADDRESS MONTGOMERY Co. 12116 Ga. ex. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE 12116 Ga. ex. COUNTY Montgomery c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wheaton Md. x9 d. STREET ADDRESS (If rural, give location) above | |
| b. FULL NAME OF HOSPITAL OR INSTITUTION Wilhelmina Heinzelung (at home) | | c. LENGTH OF STAY IN HOSPITAL IN D. C. | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Wilhelmina b. (Middle) -- c. (Last) Heinzelung | | 4. DATE OF DEATH (Month) (Day) (Year) May 10 - 57 | |
| 5. SEX 7 | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W | 8. DATE OF BIRTH 81 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11b. CITIZEN OF WHAT COUNTRY? USA | | 11a. BIRTHPLACE (State or foreign country) Germany | |
| 13. FATHER'S NAME Ludwig Benner | | 14. MOTHER'S MAIDEN NAME Ceciline Sartor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17a. INFORMANT Lillian Cree | |
| 16. SOCIAL SECURITY No. | | 17b. RELATED TO DECEDENT AS Daughter | |
| 18. MEDICAL CERTIFICATION Enter only one cause per line for (a), (b), and (c) FINAL DISEASE OR CONDITION PRECEDING DEATH I. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the cause (a) stating the underlying cause last. DUE TO (a) Cancer of Gall Bladder DUE TO (b) with abdominal metastases DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (Include report of pregnancy within 3 months of death). 450.0 Arterio Sclerosis | | years | |
| 19a. DATE OF OPERATION 4/10/57 | 19b. MAJOR FINDINGS OF OPERATION Cancer of Gall Bladder | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. AUTOPSY FINDINGS |
| 22. I hereby certify that I attended the deceased from April 23, 1957, to May 10, 1957, and last seen alive on May 10, 1957, and that death occurred at 2:50 AM from the causes and on the date stated above. | | | |
| 23a. SIGNATURE John J. Curry | | 23b. ADDRESS 10620 Glencircle | |
| 23c. DATE SIGNED 5/10/57 | | 23d. LOCATION (City, town, or county) (State) Toledo, Ohio | |
| 24a. BURIAL, CREMATION, REMOVAL 5-13-57 | | 24b. NAME OF CEMETERY OR CREMATORY Toledo Memorial Park | |
| 25a. Undertaker's Registration Number 335 | | 25b. UNDERTAKER Frank Jan | |
| 25c. ADDRESS 5406 Del. Ave NW D.C. | | DATE 5/21/57 | |

5/21/57 Frances Potter R

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------------------|--|-----------------------------------|--|-----------------------------------|--|--|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED M. J. JONES | | 2. SEX Male | | 3. AGE 45 | | 4. DATE OF BIRTH 1912 | | 5. PLACE OF BIRTH Maryland | | 6. CITY OR TOWN OF BIRTH Baltimore | | 7. COUNTY OF BIRTH Baltimore | | 8. MARITAL STATUS Married | | 9. OCCUPATION Teacher | | 10. CAUSE OF DEATH Heart Disease | | 11. PLACE OF DEATH Home | | 12. DATE OF DEATH 1957 | | 13. TIME OF DEATH 10:00 AM | | 14. SIGNATURE OF REGISTRAR J. H. Smith | | 15. SIGNATURE OF DECEASED M. J. Jones | |
| 16. NAME OF FATHER J. H. Jones | | 17. NAME OF MOTHER M. J. Jones | | 18. NAME OF SPOUSE M. J. Jones | | 19. NAME OF CHILDREN J. H. Jones, M. J. Jones | | 20. NAME OF GRANDCHILDREN J. H. Jones, M. J. Jones | | 21. NAME OF GREAT-GRANDCHILDREN J. H. Jones, M. J. Jones | | 22. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 23. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 24. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 25. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 26. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 27. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 28. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 29. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | | 30. NAME OF OTHER RELATIVES J. H. Jones, M. J. Jones | |

RECEIVED
MAY 21 1957
BUREAU V. 3

05364

CERTIFICATE OF DEATH

05335

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle Hamilton Last Higgins | | | | 4. DATE OF DEATH Month May Day 26 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 3, 1890 | |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66 | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Oil Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Oil Company | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Frank Higgins | | | | 14. MOTHER'S MAIDEN NAME Roberta Baker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NUMBER 068-07-1128 | | | |
| 17. INFORMANT The Medical Record | | | | 18. ADDRESS The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Rheumatic fever & heart disease (c) 50+ yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day INTERVAL BETWEEN ONSET AND DEATH 8+ yrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 26, 1957 to May 26, 1957 , that I last saw the deceased alive on May 26, 1957 , and that death occurred at 10:20 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Emory C. Herman, Jr. M.D. | | | | DATE SIGNED 5/27/57 | | | |
| PHYSICIAN'S NAME (Type) Emory C. Herman, Jr. | | | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMAINS (Specify) Burial | | 22b. DATE THEREOF 5/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY Forest Oak | | 22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5-28-57 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey - Bethesda, Md.

6/22/67 6/22/67

FORGET OK

RECEIVED

MAY 31 1967

BUREAU V. B.

05365

CERTIFICATE OF DEATH

05336

Reg. Dist. No. 215

| | | | | | | | |
|---|---------------------------------|---|------------------------------------|---|---|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Buncombe | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro 70X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Naval Hospital, NNMC, Bethesda, Md. | | | | d. STREET ADDRESS 910 Magnolia | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle Robert Last HINTON Jr. | | | | 4. DATE OF DEATH Month May Day 28 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-10-09 | | 9. AGE (In years last birthday) 47 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter Hinton | | | | 14. MOTHER'S MAIDEN NAME Anne Hinton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 1953-55 | | 17. INFORMANT G.W. Taylor M.D. | | Address U.S.N.H. Bethesda, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrabronchial hemorrhage 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) carcinoma of trachea and main bronchi DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-22-57 , 19____, to 5-28-57 , 19____, that I last saw the deceased alive on 5-28-57 , 19____, and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George Winston Taylor M.D. U. S. Naval Hospital, Bethesda, Md 5-28 | | | | | | | |
| ACTUAL SIGNATURE George Winston Taylor | | | | PHYSICIAN'S NAME (Type) George Winston Taylor M.D. U. S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3 June 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Buffalo Prebsyterian Cemetery Greensboro, North Carolina | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S NAME (Type) Chambers, 3072 "M" St., NW, Washington, D.C. | | | | 24a. REC'D BY REGISTRAR DATE 5-29-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| NAME OF DECEASED JOHN J. HENRY | | DATE OF DEATH 1957-05-31 | |
| PLACE OF DEATH U.S. Naval Hospital, Bethesda, Md. | | CITY AND STATE OF DEATH Bethesda, Md. | |
| AGE 68 | | SEX M | |
| RACE W | | EDUCATION High School | |
| OCCUPATION None | | MARRIAGE Married | |
| DATE OF BIRTH 1889-01-01 | | PLACE OF BIRTH St. Louis, Mo. | |
| FATHER'S NAME John J. Henry | | MOTHER'S NAME Elizabeth Henry | |
| DATE OF DEATH 1957-05-31 | | PLACE OF DEATH U.S. Naval Hospital, Bethesda, Md. | |
| CITY AND STATE OF DEATH Bethesda, Md. | | AGE 68 | |
| RACE W | | SEX M | |
| EDUCATION High School | | OCCUPATION None | |
| MARRIAGE Married | | DATE OF BIRTH 1889-01-01 | |
| FATHER'S NAME John J. Henry | | MOTHER'S NAME Elizabeth Henry | |
| DATE OF DEATH 1957-05-31 | | PLACE OF DEATH U.S. Naval Hospital, Bethesda, Md. | |
| CITY AND STATE OF DEATH Bethesda, Md. | | AGE 68 | |
| RACE W | | SEX M | |
| EDUCATION High School | | OCCUPATION None | |
| MARRIAGE Married | | DATE OF BIRTH 1889-01-01 | |
| FATHER'S NAME John J. Henry | | MOTHER'S NAME Elizabeth Henry | |

BUREAU V. 81

MAY 31 1957

RECEIVED

U.S. Naval Hospital, Bethesda, Md.

1957-05-31

U.S. Naval Hospital, Bethesda, Md.

June 1957

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05366

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05337

| | | | |
|---|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>William Alexander Howard</i> | | 4. DATE OF DEATH <i>May 7 1957</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 5/57</i> |
| 9. AGE (In years last birthday) yrs. <i>10</i> Months <i>2</i> Days <i>2</i> Hours <i></i> Min. <i></i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | |
| 11. BIRTH PLACE (State or foreign country) <i>Bethesda, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Norman Martin Howard</i> | | 14. MOTHER'S MAIDEN NAME <i>Bettie Zone Bynaker</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mother</i> | | Address <i>Same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity with</i> <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>partial atelectasis of lungs.</i> DUE TO <i>CONGENITAL ABSENCE OF ONE KIDNEY</i> (c) <i>RESIDUARY KIDNEY & BLADDER</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 5, 1957</i> , to <i>May 7, 1957</i> , that I last saw the deceased alive on <i>May 7, 1957</i> , and that death occurred at <i>4:50 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>William G. Hall, M.D.</i> M.D. | | ADDRESS (Street, city or town, state) <i>615 W. Montgomery Ave. Rockville, Md.</i> | |
| DATE SIGNED <i>5-8-57</i> | | | |
| PHYSICIAN'S NAME (Type) <i>William G. Hall, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>5/9/1957</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i> | | 22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphyrey</i> | | ADDRESS <i>7557 Wis. Ave. Bethesda, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>5-10-57</i> | | 24b. REGISTRAR'S SIGNATURE <i>Bernice M. Thompson</i> | |

A blank, aged, cream-colored page with two large, dark, irregular holes punched through it, one near the top and one near the bottom. The paper has a slightly textured appearance and some minor discoloration consistent with age.

05367

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 38 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, write street address and give nearest town) The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Valton Middle Estes Last Huffman | | | | 4. DATE OF DEATH Month May Day 8, Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3 January 1909 | |
| 9. AGE (In years last birthday) 48 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Government | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Robert E. Short | | | | 14. MOTHER'S MAIDEN NAME Laura Dadisman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 578-03-4580 | | | |
| 17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma - Rt + left lung 160X DUE TO metastatic Ca to pericardial area - increased intracranial pressure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma primary of maxillary sinus DUE TO (c) carcinoma primary of maxillary sinus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 1, 19 57, to May 8, 19 57, that I last saw the deceased alive on May 8, 19 57, and that death occurred at 1.25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 5/8/57 | | | | | | | |
| ACTUAL SIGNATURE Peter B. H'Doubler M.D. | | | | PHYSICIAN'S NAME (Type) Peter B. H'Doubler, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF May 10, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Leakesville | |
| 22d. LOCATION (City, town, or county) (State) Luray Virginia | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. B. G. Bradley | | | | ADDRESS Luray, Va. | | 24a. REC'D BY REGISTRAR DATE 5-11-57 | |
| 24b. REGISTRAR'S SIGNATURE Burris M. Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

MAY 13 1957

RECEIVED

05298

CERTIFICATE OF DEATH

05340

Reg. Dist. No. 223

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u> | | | | d. STREET ADDRESS <u>412 Lincoln Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Bonnie</u> Middle <u>Louise</u> Last <u>Hutchison</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-9-56</u> | |
| 9. AGE (In years lost birthday) yrs. <u>1</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | | |
| 13. FATHER'S NAME <u>Morris Hutchison</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anne Muderman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>Hospital Records</u> | | | | Address <u>—</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11:30 p. 5-16, 1957</u> , to <u>3:30 p. 5-17, 1957</u> , that I last saw the deceased alive on <u>5-17-57</u> , 19 <u> </u> , and that death occurred at <u>3:30 p. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ruth Standard M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Washington San Hosp</u> DATE SIGNED <u>5-17-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Ruth Standard</u> | | | | <u>Takoma Park</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 20, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Pascha Sons Hyattsville Md.</u> | | | | ADDRESS <u> </u> | | 24a. REC'D BY REGISTRAR DATE <u>5/31/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1957

RECEIVED
JAN 21 1957

05368

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 119 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Dorothy Middle Andre Last Inman | | | | 4. DATE OF DEATH Month May Day 30 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 29, 1926 | |
| 9. AGE (In years last birthday) 31 yrs. | | IF UNDER 1 YEAR Months 31 Days 31 Hours 31 Min. | | IF UNDER 24 HRS. Months 31 Days 31 Hours 31 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME N. John Ferguson | | | | 14. MOTHER'S MAIDEN NAME Regina Campbell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 301-22-7359 | | | |
| 17. INFORMANT The Medical Record | | | | Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (L) lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from January 31, 1957 , to May 30, 1957 , that I last saw the deceased alive on May 30, 1957 , and that death occurred at 11:33 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert Austin Milch M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| DATE SIGNED 6-1-57 | | | | | | | |
| PHYSICIAN'S NAME (Type) ROBERT AUSTIN MILCH, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-5-57 | | 22c. NAME OF CEMETERY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. | | | | 24. RECEIVED BY REGISTRAR June 5, 1957 25. REGISTRAR'S SIGNATURE Basile Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18 1981

BUREAU V. S.

JUN 5 1967

RECEIVED

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Nursing Home | | d. STREET ADDRESS 7120 Maple Avenue | |
| 3. NAME OF DECEASED (Type or print) First LOCRETIA Middle JACKSON Last JACKSON | | 4. DATE OF DEATH Month MAY Day 2 Year 1957 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/28/1870 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. War Dept. Govt. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Israel Mauditt Jackson | | 14. MOTHER'S MAIDEN NAME Sarah E. Parris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Dr. Ruth Jackson | | Address 5404 Illinois Ave., N.W. Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MARCH 1, 1952 to MAY 2, 1957 , that I last saw the deceased alive on MAY 2, 1957 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry M. Lowden M.D. | | ADDRESS (Street, city or town, state) 5206 NORWAY DR. WASHINGTON, D.C. | |
| DATE SIGNED 5/1/57 | | | |
| PHYSICIAN'S NAME (Type) HENRY M. LOWDEN | | CHEVY CHASE, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/4/57 | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Kines Co. | | ADDRESS 2901 14th St. N.W. Washington, D.C. | |
| 24a. REC'D BY REGISTRAR MAY 3 1957 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

BUREAU V. 11

MAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Maryland Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| c. LENGTH OF STAY IN 1b DOA | | | | d. STREET ADDRESS 812 "G" St., S.E. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle Earl Last JACOBS | | | | 4. DATE OF DEATH Month May Day 29 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4 Jan. 1900 | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US MARINE CORPS | | | | 10b. KIND OF BUSINESS OR INDUSTRY US GOV'T | | 11. BIRTHPLACE (State or foreign country) Tennessee | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME William R. Jacobs | | | | 14. MOTHER'S MAIDEN NAME Blanch Sale | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW-II | | 17. INFORMANT Official Navy Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart, MD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 5-29-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-4-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Chamber's Funeral Home | | | | 24a. REC'D BY REGISTRAR DATE 5-30-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

(100/100) 100/100

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Both

BUREAU V. 5

UN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05344
05371 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|---|--|--------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY MONTGOMERY | MARYLAND | STATE MARYLAND | COUNTY MONTGOMERY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING | LENGTH OF STAY (in this place) 8 yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 2106 ROSS ROAD | | STREET ADDRESS 2106 ROSS ROAD | |

| | | | | | |
|--------------------------|-----------------------------|---|---|--|--|
| 3. NAME OF DECEASED: | | | 4. DATE (Month) (Day) (Year) | | |
| (First) Christine | (Middle) LAYNAUD | (Last) JAQUES | DATE OF DEATH: MAY 27 1957 | | |
| 5. SEX: FEMALE | 6. COLOR OR WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED | 8. DATE OF BIRTH: NOV. 22, 1885 | | 9. AGE last birthday 71 yrs. |
| | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | Months Days | | Hours Min. |

| | | | |
|---|---|--|---|
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE | 10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME | 11. BIRTHPLACE (State or foreign country): Louisiana | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|---|--|---|

| | |
|--|--|
| 13. FATHER'S NAME: AUGUSTE LAYNAUD | 14. MOTHER'S MAIDEN NAME: ANNAIS CROZIER |
|--|--|

| | | |
|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO | 16. SOCIAL SECURITY No. 436-03-1508 A | 17. INFORMANT & ADDRESS: Mr. Theodore Jaques, 2106 Ross Rd. Silver Spring, Md. |
|--|---|--|

| | | |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| IMMEDIATE CAUSE (A) CARCINOMATOSIS, primary undet. 199.9 | | 3 mos |
| ANTECEDENT CAUSE (S) DUE TO examined. | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | |
| (B) DUE TO | | |
| (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |

| | | |
|--|--|---|
| 19A. DATE OF OPERATION: April 4 1957 | 19B. MAJOR FINDINGS OF OPERATION: CARCINOMATOSIS | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

| | | |
|--|--|---|
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **May 26, 1957**, to **MAY 26, 1957**, that I last saw the deceased alive on **May 26, 1957**, and that death occurred at **7:30 A** M, from the causes and on the date stated above.

SIGNATURE **Cefra Bigulio** ADDRESS **1035 E. E. N. H. 27 May 57** DATE SIGNED

| | | | |
|---|--------------------------------|---|---|
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 5/29/57 | NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD. |
|---|--------------------------------|---|---|

| | | | |
|---|---|---|---|
| DATE REC'D BY LOCAL REGISTRAR 5-31-57 | REGISTRAR'S SIGNATURE Frances Otter | 24. FUNERAL DIRECTOR Walter E. Humphrey | ADDRESS SILVER SPRING, MARYLAND |
|---|---|---|---|

RECEIVED

JUN 6 1957

BUREAU V. S.

05372

Items 13, 14 Film 6215 5-23-57 et

CERTIFICATE OF DEATH

05345

Reg. Dist. No. 216

| | | | | | | | |
|---|-----------------------------------|---|---------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47 x 3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | d. STREET ADDRESS <u>2430 Pa Ave NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Flemming Jenks</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 13 1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-1-96</u> | 9. AGE (In years last birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>ILL.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | | | | |
| 13. FATHER'S NAME <u>James B. Jenks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bertha Newcombe</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>HOSPITAL RECORD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>154X METASTATIC CARCINOMA OF LUNGS</u> DUE TO (b) <u>CARCINOMA OF RECTUM</u> DUE TO (c) <u>GENERALIZED CARCINOMATOSIS</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>20 MONTHS</u> <u>5 1/2 YRS</u> <u>18 MONTHS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DECUBITUS/ULCER PRE-SACRAL</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>MARCH 30, 1950</u> , to <u>May 13, 1957</u> , that I last saw the deceased alive on <u>May 12, 1957</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D. <u>5009 1st Bay Ave Bethesda, Md 2/13/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/15/57</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington RD Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chevy Chase Fun. Home.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-17-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05346

05373

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montg. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 16 (Bethesda)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>5526 Monsey Lane</u> | |
| 3. NAME OF DECEASED (Type or print) <u>BABY GIRL JOHNSON</u> | | 4. DATE OF DEATH <u>MAY 19 1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 19, 1957</u> |
| 9. AGE (In years lost birthday) yrs. <u>1</u> | | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>30</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WESLEY JOHNSON</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ELIZA DORSEY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>MOTHER</u> | | Address <u>— SAME AS ABOVE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY - (weight 9oz)</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 12, 1957</u> to <u>May 19, 1957</u> , that I last saw the deceased alive on <u>May 19, 1957</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2203 Wyoming Ave., N.W.</u> DATE SIGNED <u>—</u> | | | |
| ACTUAL SIGNATURE <u>M. H. Rosvener</u> | | PHYSICIAN'S NAME (Type) <u>M. H. Rosvener</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5/24/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u> | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u> | | 24a. REC'D BY REGISTRAR <u>MAY 27 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> |

2074264XVO

CERTIFICATE OF DEATH

| | | | | | |
|--|--|------------------------------------|--|--|--|
| 1. NAME OF DECEASED BURKAY, Y. J. | | 2. SEX Male | | 3. AGE 35 | |
| 4. DATE OF DEATH May 27, 1957 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH Home | |
| 7. CAUSE OF DEATH Myocardial Infarction | | 8. MANNER OF DEATH Natural | | 9. PLACE OF BIRTH New York City | |
| 10. OCCUPATION Salesman | | 11. EDUCATION High School | | 12. MARITAL STATUS Married | |
| 13. PREVIOUS ILLNESS None | | 14. MEDICAL HISTORY None | | 15. PHYSICIAN'S SIGNATURE [Signature] | |
| 16. SIGNATURE OF DECEASED None | | 17. SIGNATURE OF WITNESSES None | | 18. SIGNATURE OF REGISTRAR None | |

RECEIVED
MAY 27 1957
BURKAY, Y. J.

05374

CERTIFICATE OF DEATH

05347
214

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Geo</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md 16x22</u> ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LANE NURSING HOME</u> | | d. STREET ADDRESS <u>6103 Arbor St</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ELBERT</u> Middle <u>H</u> Last <u>JOHNSON</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 5, 1874</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired US Govt Cabinet Maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bluemont Va</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Richard M Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Emily Pidgeon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Richard M Johnson (son)</u> | |
| 17. INFORMANT <u>Richard M Johnson (son)</u> | | Address <u>6103 Arbor St Cheverly Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 SENILITY</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>APRIL 23, 1957</u> , to <u>MAY 31, 1957</u> , that I last saw the deceased alive on <u>MAY 31, 1957</u> , and that death occurred at <u>3:32 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D. | | ADDRESS (Street, city or town, state) <u>5206 Norway Dr Chevy Chase, Md</u> | |
| DATE SIGNED <u>5-31-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>6-3-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington DC</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leaf Funeral Home</u> | | ADDRESS <u>4812 Ga Ave NW</u> | |
| 24a. REC'D BY REGISTRAR <u>HUN 4</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 4 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05375

CERTIFICATE OF DEATH

05348

Reg. Dist. No.

214

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14,511 Colesville Road MARLEA NURSING HOME | | d. STREET ADDRESS 14,511 Colesville Road | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE B. JOHNSON | | 4. DATE OF DEATH Month Day Year May 22, 1957 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/28/82 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress maker (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) FRANCE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME RAUL DeLABRUYRE | | 14. MOTHER'S MAIDEN NAME JULIA LARD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Address Mrs. Bertha Myers, Marlea Nursing Home Silver Spring, Md. | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma (primary site unknown) 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 33. Hypertensive endocardial disease 23. Parkinsonism 10 years | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 55 , to May 22 , 19 57 , that I last saw the deceased alive on May 21 , 19 57 , and that death occurred at 4:39 AM , from the causes and on the date stated above. DATE SIGNED 5-22-57 | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | ADDRESS (Street, city or town, state) 1915 Linnay Rd. Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) JOHN S. ROGERS | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/23/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) (State) SILVER SPRING, MONTGOMERY CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey | | 24a. REC'D BY REGISTRAR 5/31/57 | |
| 24b. REGISTRAR'S SIGNATURE Frances Potter | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED [Illegible]</p> | | <p>2. SEX [Illegible]</p> | |
| <p>3. AGE [Illegible]</p> | | <p>4. DATE OF BIRTH [Illegible]</p> | |
| <p>5. PLACE OF BIRTH [Illegible]</p> | | <p>6. OCCUPATION [Illegible]</p> | |
| <p>7. MARITAL STATUS [Illegible]</p> | | <p>8. CAUSE OF DEATH [Illegible]</p> | |
| <p>9. MANNER OF DEATH [Illegible]</p> | | <p>10. DATE OF DEATH [Illegible]</p> | |
| <p>11. PLACE OF DEATH [Illegible]</p> | | <p>12. SIGNATURE OF DECEASED [Illegible]</p> | |
| <p>13. SIGNATURE OF WITNESS [Illegible]</p> | | <p>14. SIGNATURE OF PHYSICIAN [Illegible]</p> | |
| <p>15. SIGNATURE OF CLERK [Illegible]</p> | | <p>16. SIGNATURE OF REGISTRAR [Illegible]</p> | |

BUREAU V. S.

JUN 6 1957

RECEIVED

05376

CERTIFICATE OF DEATH

05350

Reg. Dist. No. 215

| | | | | | |
|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington 83X-3</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | d. STREET ADDRESS <u>1401 N. Taylor Street</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>JONES</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>19 57</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>18 Feb. 1887</u> | 9. AGE (In years last birthday) <u>70</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Moulder</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Manufacturing</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 13. FATHER'S NAME <u>Thomas Jones</u> | | | 14. MOTHER'S MAIDEN NAME <u>Emma Goodwin</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT <u>(Daughter) Mildred E. Jones (Same As #2)</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases.</u> DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>8 February, 1957</u> , to <u>8 May, 1957</u> , that I last saw the deceased alive on <u>8 May, 1957</u> , and that death occurred at <u>9:10 P. M.</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Melvin Rotner</u> | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 5-9-57</u> | | |
| PHYSICIAN'S NAME (Type) <u>Melvin Rotner, LT, MC, USN</u> | | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5-11-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>West Minister Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Birch's Funeral Home</u> | | | 24a. REC'D BY REGISTRAR DATE <u>5-9-57</u> | | |
| ADDRESS <u>Birch's Funeral Home, 3034 M. St., N.W. Wash.D.C.</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Mary C. Ransley</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|---|--|--|--|
| NAME OF DECEASED (Print name in full) | | SEX (Male or Female) | |
| DATE OF BIRTH (Month, Day, Year) | | PLACE OF BIRTH (City, State, Country) | |
| OCCUPATION (If deceased was engaged in any occupation, trade, profession, or service, state it here) | | CAUSE OF DEATH (State the cause of death in full, giving the immediate cause, and the disease or injury which caused it, and the condition which led to it, if known) | |
| PLACE OF DEATH (City, State, Country) | | TIME OF DEATH (Hour, Minute) | |
| SIGNATURE OF DECEASED (If deceased was capable of signing, state the signature) | | SIGNATURE OF WITNESSES (If deceased was incapable of signing, state the signatures of two or more persons who saw the deceased at the time of death) | |
| SIGNATURE OF PHYSICIAN (If deceased was under the care of a physician, state the signature) | | SIGNATURE OF CORONER (If deceased was found dead, state the signature) | |
| SIGNATURE OF JUDGE (If deceased was found dead, state the signature) | | SIGNATURE OF CLERK (If deceased was found dead, state the signature) | |

BUREAU V. B.

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05351

05377

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | c. LENGTH OF STAY IN 1b 16 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 1939-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Littleton Last Justice | | 4. DATE OF DEATH Month May Day 14 Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 8, 1888 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Ship Carpentry | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Edward Justice | |
| 14. MOTHER'S MAIDEN NAME Maggie Parks | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edward Justice- Address Hyattsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyloric obstruction 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, stomach (c) Peptic ulcer (p?) | | INTERVAL BETWEEN ONSET AND DEATH 5 wks. 1 yr. OK? 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0 Cirrhosis of liver | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. 27, 1957 to May 14, 1957 , that I last saw the deceased alive on May 14, 1957 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Maryland DATE SIGNED 5/14/57 | | | |
| ACTUAL SIGNATURE Philip H. Varner M.D. | | PHYSICIAN'S NAME (Type) Philip H. Varner | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/17/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery | | 22d. LOCATION (City, town, or county) (State) Crisfield, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, | | ADDRESS Crisfield, Maryland | |
| 24a. REC'D BY REGISTRAR DATE 5/20/57 | | 24b. REGISTRAR'S SIGNATURE Beulah Thompson W | |

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | | AGE [Faint text, possibly "45"] | | DATE OF BIRTH [Faint text, possibly "1912"] | |
| PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."] | | OCCUPATION [Faint text, possibly "Teacher"] | | CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | |
| DATE OF DEATH [Faint text, possibly "Jan 15, 1957"] | | TIME OF DEATH [Faint text, possibly "10:30 AM"] | | PLACE OF DEATH [Faint text, possibly "Home"] | | SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"] | |
| SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"] | | SIGNATURE OF WITNESS [Faint text, possibly "C. D. Brown"] | | SIGNATURE OF DECEASED [Faint text, possibly "John Doe"] | | SIGNATURE OF NEAREST RELATIVE [Faint text, possibly "Mrs. J. Doe"] | |

BUREAU V. B.

NO 20 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05352

05378

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>28 days</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>X2</u> d. STREET ADDRESS <u>4905-Asbury Dr.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>ESTELLE</u> First <u>KEARNEY</u> Middle Last 4. DATE OF DEATH <u>MAY</u> Month <u>22</u> Day <u>1957</u> Year | | | | 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug-3-79</u> 9. AGE (In years last birthday) <u>77</u> yrs. | | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Joseph Monahan</u> 14. MOTHER'S MAIDEN NAME <u>Mary Curran</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Richard D. Kearney - son.</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Malnutrition</u> <u>491X</u> DUE TO <u>② Mental Depression</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubiti & Infection</u> DUE TO (c) <u>Pneumonia</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>March, 1957</u> , to <u>May 21, 1957</u> , that I last saw the deceased alive on <u>March 19</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Dr. William Joyce</u> ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd Bethesda, Md</u> DATE SIGNED <u>5/31/57</u> | | | | PHYSICIAN'S NAME (Type) <u>Dr. William Joyce</u> | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 22b. DATE THEREOF <u>May 22/1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph</u> 22d. LOCATION (City, town, or county) (State) <u>Cincinnati Ohio</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Murphy</u> ADDRESS <u>Cal. Va</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 5-29-57</u> 24b. REGISTRAR'S SIGNATURE <u>Beau M. Shoup</u> | | | | | |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05353

05373

CERTIFICATE OF DEATH

Reg. Dist. No. 212

| | | | | | | | |
|---|-------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. LENGTH OF STAY IN 1b <u>2 year</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 King William Dr.</u> | | | | d. STREET ADDRESS <u>1206 King William Dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Marie</u> Last <u>KEEGIN</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Wh</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 14, 1913</u> | | 9. AGE (In years last birthday) <u>43</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing - Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Arvid Elihn</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sigrid Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>WW II</u> | | 17. INFORMANT <u>Leonard B. Keegin</u> Address <u>Olney Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>224X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left adrenal adenoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>11</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>57</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Olney, Md.</u> DATE SIGNED <u>5-5-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 7, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u> | | 22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Barber, Laytonville, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-6-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u> | |

CERTIFICATE OF DEATH

111

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF BIRTH <i>May 15, 1910</i> | | 5. PLACE OF BIRTH <i>Baltimore, Md.</i> | | 6. OCCUPATION <i>Teacher</i> | |
| 7. DATE OF DEATH <i>May 20, 1957</i> | | 8. PLACE OF DEATH <i>Home</i> | | 9. CAUSE OF DEATH <i>Heart Disease</i> | |
| 10. MEDICAL HISTORY <i>None</i> | | 11. PRESENT ILLNESS <i>None</i> | | 12. SIGNATURE OF PHYSICIAN <i>[Signature]</i> | |
| 13. SIGNATURE OF DECEASED <i>[Signature]</i> | | 14. SIGNATURE OF WITNESS <i>[Signature]</i> | | 15. SIGNATURE OF REGISTRAR <i>[Signature]</i> | |
| 16. SIGNATURE OF CLERK <i>[Signature]</i> | | 17. SIGNATURE OF JUDGE <i>[Signature]</i> | | 18. SIGNATURE OF SHERIFF <i>[Signature]</i> | |
| 19. SIGNATURE OF DISTRICT ATTORNEY <i>[Signature]</i> | | 20. SIGNATURE OF COUNTY CLERK <i>[Signature]</i> | | 21. SIGNATURE OF CITY CLERK <i>[Signature]</i> | |
| 22. SIGNATURE OF STATE CLERK <i>[Signature]</i> | | 23. SIGNATURE OF FEDERAL CLERK <i>[Signature]</i> | | 24. SIGNATURE OF POSTAL CLERK <i>[Signature]</i> | |
| 25. SIGNATURE OF TELEPHONE CLERK <i>[Signature]</i> | | 26. SIGNATURE OF RAILROAD CLERK <i>[Signature]</i> | | 27. SIGNATURE OF AIRLINE CLERK <i>[Signature]</i> | |
| 28. SIGNATURE OF MARINE CLERK <i>[Signature]</i> | | 29. SIGNATURE OF NAVY CLERK <i>[Signature]</i> | | 30. SIGNATURE OF ARMY CLERK <i>[Signature]</i> | |
| 31. SIGNATURE OF AIR FORCE CLERK <i>[Signature]</i> | | 32. SIGNATURE OF SPACE CLERK <i>[Signature]</i> | | 33. SIGNATURE OF OTHER CLERK <i>[Signature]</i> | |

*Left school admission
Certificate about June
1957*

BUREAU V. E

MAY 9 1957

RECEIVED

05380

CERTIFICATE OF DEATH

Reg. Dist. No. 05354

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 57 days | | | |
| d. NAME OF HOSPITAL (If not in this hospital, give name and address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS 5601 Pollard Road | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Joseph Last Kemp | | | | 4. DATE OF DEATH Month May Day 2 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 22 February 1895 | |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | | | 10b. KIND OF BUSINESS OR INDUSTRY Professional | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Simon J. Kemp | | | | 14. MOTHER'S MAIDEN NAME Kate Worthington | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Metastases 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal Cell Carcinoma DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis - generalized | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March 6, 19 57 , to May 2, 19 57 , that I last saw the deceased alive on May 2, 19 57 , and that death occurred at 5.20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Md. DATE SIGNED 5/3/57 | | | | | | | |
| ACTUAL SIGNATURE John Laszlo, M.D. | | | | PHYSICIAN'S NAME (Type) John Laszlo, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/6/57 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5-6-57 | | 24b. REGISTRAR'S SIGNATURE James M. Thompson | |

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. The attending physician and completely filled in by the attending physician and completely filled in by the attending physician.

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 7 1957

BUREAU Y. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05381

CERTIFICATE OF DEATH

05355

Reg. Dist. No. 217

| | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 18 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. Inc. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Maud Middle Elizabeth Last Keneipp | | | | 4. DATE OF DEATH Month May Day 7 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/17/90 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months 66 | | IF UNDER 24 HRS. Days 66 Hours 66 Min. 66 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y. (retired) L.C. Smith Typewriter Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Smith Typewriter Co. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | | | | | | |
| 13. FATHER'S NAME John M. Leonard | | | | 14. MOTHER'S MAIDEN NAME Lydia B. Lauver | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 578-01-2610 | | 17. INFORMANT Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis coronary artery disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO 3 months (c) Uterine fibroids DUE TO 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 214X | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 6 yrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from June , 1956, to May , 1957, that I last saw the deceased alive on May 7 , 1957, and that death occurred at 9:00 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. D. Bonifant | | | | ADDRESS (Street, city or town, state) Sandy Spring, Maryland | | | |
| PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D. | | | | DATE SIGNED 5/7/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 5/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | |
| 22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. | | | | 22e. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey | | | | ADDRESS SILVER SPRING, MARYLAND | | 24a. REC'D BY REGISTRAR 5-9-57 | |
| 24b. REGISTRAR'S SIGNATURE Gertrude B. Lawley | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 13 18

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05382

CERTIFICATE OF DEATH

Reg. Dist. No.

053564
214

| | | | |
|--|----------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville X2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mary Lee Nursing Home | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Frances Kidd | | 4. DATE OF DEATH Month Day Year May 10, 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1874 |
| 9. AGE (In years last birthday) 83 (yrs) | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Mould (?) | | 14. MOTHER'S MAIDEN NAME Catherine Redeker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Capt. F. F. Agens, USN, 1433 Harbor Oaks Rd., Jacksonville 7, Florida | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis and hypertensive heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 20 hrs. Yes. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 30, 1949 to May 10, 1957 , that I last saw the deceased alive on May 9, 1957 , and that death occurred at 1A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 1919 Seminary Rd., Silver Spring, Md. May 10, 1957 | |
| PHYSICIAN'S NAME (Type) John S. Rogers | | 1919 Seminary Rd., Silver Sp., Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 5/10/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bawler's Sons, 1756 Pa. Ave., N.W., D.C. | | 24a. REC'D BY REGISTRAR DATE 5/15/57 | |
| 24b. REGISTRAR'S SIGNATURE Francis Potter | | | |

05383

CERTIFICATE OF DEATH

05357

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>3 mos. 9 days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u> | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| d. STREET ADDRESS <u>3005 32nd St., N.W.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Grace</u> Last <u>KINTNER</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11 March 1883</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Alexander P. Grice</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susan T. Brooks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>(Husband) Edwin G. Kintner (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoid, intestinal with</u> <u>211X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>widespread metastases</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>29 Jan.</u> , 19 <u>57</u> , to <u>6 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 May</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-6-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>G. W. Russell</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>G. W. RUSSELL, CAPT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-9-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>GAWLER'S & SONS, 1756 Penn. Ave., N.W. Wash. D.C.</u> | | | | ADDRESS <u>1756 Penn. Ave., N.W. Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>5-6-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary B. Parrelly</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

05299

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>700 Chillum Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>(NMN)</u> Last <u>Knopp</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>II-10-84</u> | 9. AGE (In years lost birthday) <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | |
| 13. FATHER'S NAME <u>Solomon Ferdman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ethel Malinsky</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 17. INFORMANT <u>Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs</u> <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 1951, to <u>May 17</u> , 1957, that I last saw the deceased alive on <u>May 17</u> , 1957, and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Isidore Shulman</u> | | | | DATE SIGNED <u>May 19 1957</u> | | | |
| PHYSICIAN'S NAME (Type) <u>I. Shulman</u> | | | | ADDRESS (Street, city or town, state) <u>Wash. 6. D. C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town or county) (State) | |
| <u>Interred</u> | | <u>May 19, 1954</u> | | <u>Willow Cemetery</u> | | <u>Brooklyn, N. Y.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | | | ADDRESS <u>254 Carroll at New L.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>2/20/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadd</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15739

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Registration No.

| | | | |
|--|--|---|--|
| <p>1. NAME OF DECEASED LAST NAME FIRST MIDDLE (Print or write full name)</p> | | <p>2. SEX Male Female</p> | |
| <p>3. AGE (In years, months, and days)</p> | | <p>4. DATE OF BIRTH (Month, day, year)</p> | |
| <p>5. PLACE OF BIRTH (City, State, and Country)</p> | | <p>6. OCCUPATION (If deceased was engaged in any occupation, trade, or profession, state it)</p> | |
| <p>7. MARITAL STATUS Single Married Widowed Divorced</p> | | <p>8. DATE OF DEATH (Month, day, year)</p> | |
| <p>9. TIME OF DEATH (Hour, minute)</p> | | <p>10. PLACE OF DEATH (City, State, and Country)</p> | |
| <p>11. CAUSE OF DEATH (State the immediate cause of death, and if known, the remote cause)</p> | | <p>12. SIGNATURE OF DECEASED (If deceased was able to sign, print name)</p> | |
| <p>13. SIGNATURE OF WITNESSES (Print names of two persons who saw the deceased die, or who were present at the time of death)</p> | | <p>14. SIGNATURE OF PHYSICIAN (Print name of physician who attended the deceased, or who was called in consultation)</p> | |
| <p>15. SIGNATURE OF REGISTRAR (Print name of registrar who issued this certificate)</p> | | <p>16. SIGNATURE OF CLERK (Print name of clerk who issued this certificate)</p> | |

BUREAU V. 21

MAY 21 1957

RECEIVED

05384

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5852 Marbury Road | | | | d. STREET ADDRESS 5852 Marbury Road | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle A. Last KOEHLER | | | | 4. DATE OF DEATH Month May Day 15 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/22/91 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 4 Days 23 | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Glazing | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME George A. Koehler | | | | 14. MOTHER'S MAIDEN NAME Charlotte Fluke | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Mrs Katherine M, Koehler-Item#2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia hypostatic, terminal 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure DUE TO (c) Rheumatic heart disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2da 24rs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 723.0 Osteoarthritis, spinal | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from May 13, 1957 , to May 15, 1957 , that I last saw the deceased alive on May 15, 1957 , and that death occurred at 2:00 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Philip H. Varner , M.D. | | | | ADDRESS (Street, city or town, state) 10620 Georgia Avenue, Silver Spring, Md. | | | |
| PHYSICIAN'S NAME (Type) Philip H. Varner, M.D. | | | | DATE SIGNED 5/15/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/18/57 | | 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 22d. LOCATION (City, town, or county) (State) Aspen Hill, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bethesda, Md. Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR DATE 5-20-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Pumphrey | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05385

CERTIFICATE OF DEATH

05360

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 20 min's | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | d. STREET ADDRESS 10100 Cedar Lane | |
| 3. NAME OF DECEASED (Type or print) Philip First J Middle Kolb Last | | 4. DATE OF DEATH May 18 1957 Month May Day 18 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 6, 1886 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Supervisor Retired U.S. Govt. | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 11. BIRTHPLACE (State or foreign country) New York State | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Albert Kolb | | 14. MOTHER'S MAIDEN NAME Mary Coughlin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — — — — — | |
| 17. INFORMANT Ruth Wenrick Address 10100 Cedar Lane, Kensington, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Unknown | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Generalized arterio sclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov 18, 1956 to May 18, 1957 , that I last saw the deceased alive on May 18, 1957 , and that death occurred at 7:50 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edmund S. Norton | | M.D. 4711 Highland Ave | |
| PHYSICIAN'S NAME (Type) Bethesda 14, Md. | | DATE SIGNED 5/18/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 22b. DATE THEREOF 5/19/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY North Wood | | 22d. LOCATION (City, town, or county) (State) Philadelphia, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | ADDRESS — — — — — | |
| 24a. REC'D BY REGISTRAR 5-21-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

10552

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. GILBERT</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1912</u></p> | | <p>4. Place of birth: <u>NEW YORK</u></p> | |
| <p>5. Date of death: <u>1957</u></p> | | <p>6. Place of death: <u>NEW YORK</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Immediate cause: <u>Myocardial Infarction</u></p> | |
| <p>9. Contributing causes: <u>None</u></p> | | <p>10. Manner of death: <u>Natural</u></p> | |
| <p>11. Signature of physician: <u>[Signature]</u></p> | | <p>12. Signature of registrar: <u>[Signature]</u></p> | |
| <p>13. Date of registration: <u>1957</u></p> | | <p>14. Place of registration: <u>NEW YORK</u></p> | |

BUREAU V. 81

APR 23 1957

RECEIVED

05386

CERTIFICATE OF DEATH

Reg. Dist. No. 210

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | d. STREET ADDRESS <u>1509 VAN BUREN ST NW</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>DAVID</u> Last <u>Lamie</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-15-82</u> | 9. AGE (In years last birthday) <u>74</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical engineer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Lamie</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Liza Clarke</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hospital record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-15-55</u> , 19____, to <u>5-10-57</u> , 19____, that I last saw the deceased alive on <u>5-9-57</u> , 19____, and that death occurred at <u>7:15</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Andrew J. Betz</u> | | | | M.D. <u>5412 Colo. Ave. N.W.</u> | | DATE SIGNED <u>5-10-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Andrew J. Betz</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/13/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company Washington, D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 5/13/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mary Carroll</u> <u>David Thompson</u> | |

BUREAU

1957 13 1957

RECEIVED
MAY 13 1957

05387

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 1614.2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 4221 Knox Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Patricia Middle Dee Last Land | | 4. DATE OF DEATH | | Month May Day 31 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 25, 1951 | | 9. AGE (In years last birthday) yrs. 5 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James T. Land | | | | 14. MOTHER'S MAIDEN NAME Grace Crawford | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONG. Heart Disease - Ventricular 754.4 DUE TO hypertrophy and dilation of RV Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Death at time of surgery (c) Death at time of surgery | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 19 , 19 57 , to May 31 , 19 57 , that I last saw the deceased alive on May 31 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/1/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE Richard J. Sanders | | M.D. Richard J. Sanders, M. D. | | ADDRESS (Street, city or town, state) Bethesda 14, Maryland | | DATE SIGNED 6/1/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/4/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE 6/3/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. S.

JUN 5 1957

RECEIVED

05388

CERTIFICATE OF DEATH

Reg. Dist. No. 246

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X20HEVY CHASE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN</u> | | d. STREET ADDRESS <u>137 OXFORD ST.</u> | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | |
|---|----------------------------------|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALBERT</u> Last <u>LANE</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 2 - 1868</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ARCHITECT</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MASS.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |

| | | | |
|---|--|--|--|
| 13. FATHER'S NAME <u>JAMES P. LANE</u> | | 14. MOTHER'S MAIDEN NAME <u>EMMA PILLSBURY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT <u>DONALD E. LANE</u> | | Address <u>37 OXFORD ST.</u> | |

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of Rt. auricular appendage</u> DUE TO (c) <u>Auricular Fibrillation</u> | | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

| | | |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>446X Arteriosclerotic nephrosclerosis & terminal uremia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|--|--|---|

| | | | |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | | |
|---|--|-------------|
| 21. I certify that I attended the deceased from _____, 1950, to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 27, 1957</u> , and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above. | | DATE SIGNED |
| ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St. N.W.</u> | | |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash 15 D.C.</u> <u>5-28-57</u> | | |

| | | | |
|--|---|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 22b. DATE THEREOF <u>May 28 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 22d. LOCATION (City, town, or county) (State) <u>Scitland Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheryl Chase Funeral Home</u> | | 24a. REC'D BY REGISTRAR <u>5703 Wis.</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|--------------------------------------|--|--|--|--------------------------------------|--|---------------------------------|--|
| NAME OF DECEASED MAYNARD | | SEX M | | AGE 82 | | DATE OF BIRTH JAN 18 1882 | |
| PLACE OF BIRTH BALTIMORE | | CITY OF BIRTH BALTIMORE | | STATE OF BIRTH MD | | COUNTRY OF BIRTH USA | |
| DATE OF DEATH JUN 3 1957 | | PLACE OF DEATH BALTIMORE | | CITY OF DEATH BALTIMORE | | STATE OF DEATH MD | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | | PERMANENT OR TEMPORARY PERMANENT | | OCCUPATION RETIRED | |
| DATE OF EXAMINATION JUN 3 1957 | | PLACE OF EXAMINATION BALTIMORE | | CITY OF EXAMINATION BALTIMORE | | STATE OF EXAMINATION MD | |
| NAME OF PHYSICIAN DR. J. H. SMITH | | NAME OF PATHOLOGIST DR. J. H. SMITH | | NAME OF ANATOMIST DR. J. H. SMITH | | NAME OF CLERK J. H. SMITH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PATHOLOGIST | | SIGNATURE OF ANATOMIST | | SIGNATURE OF CLERK | |
| DATE OF SIGNATURE JUN 3 1957 | | DATE OF SIGNATURE JUN 3 1957 | | DATE OF SIGNATURE JUN 3 1957 | | DATE OF SIGNATURE JUN 3 1957 | |

BUREAU V. S.

JUN 3 1957

RECEIVED

05389

CERTIFICATE OF DEATH

05364

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 1 Mo. 17 days x2 | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | |
| d. STREET ADDRESS 4321 Rosedale Ave., | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Annette | | First Blanche | | Middle LEMON | | Lost | |
| 4. DATE OF DEATH May | | Month 12 | | Day 19 | | Year 57 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 16 July 1875 | |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME William Henry Small | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Small | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT (Son-in-law) William J. Carroll (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 089x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) infectious parotitis DUE TO Debility following CVA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enterotoxigenic Escherichia - left femoral neck | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 6 weeks | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 9048 a/c | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 9 p.m. 3-25-57 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | |
| 20f. (City or town) Bethesda, | | | | 20g. (County) Montgomery, | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 26 March , 19 57 , to 12 May , 19 57 , that I last saw the deceased alive on 12 May , 19 57 , and that death occurred at 9:05 P.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-13-57 | | | | | | | |
| ACTUAL SIGNATURE J. W. Bickerstaff, Jr. M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) J. W. BICKERSTAFF, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 15 May 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Lee Sons Co | | | | ADDRESS 400-4th St. N.W. Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE 5-13-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Connelly | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14 1957

RECEIVED
JUN 14 1957

05390

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | d. STREET ADDRESS 4885 Battery Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Hodge Middle None Last Lester | | | | 4. DATE OF DEATH Month May Day 1 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 6, 1892 | | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months 4 Days 25 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Attorney | | 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Lester | | | | 14. MOTHER'S MAIDEN NAME Dona Hillman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1st World War 253-01-4333 | | 17. INFORMANT Irene F Lester 4885 Battery Lane, Bethesda, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) cerebral thrombosis DUE TO (c) generalized arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 27 , 19 57 , to May 1 , 19 57 , that I last saw the deceased alive on April 30 , 19 57 , and that death occurred at 5:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4861 A Battery Lane, Bethesda DATE SIGNED 5/1/57 ACTUAL SIGNATURE Wilfred R. Ehrmantrant M.D. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantrant | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/6/57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE 5-2-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Beattie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

FILE NO.

| | | | |
|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| SEX | | RACE | |
| MARRIAGE | | EDUCATION | |
| OCCUPATION | | RELIGION | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |

BUREAU V. 3

MAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05366

05391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | | | | | |
|--|--|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen Hosp | | | | d. STREET ADDRESS Cedar Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Fra nk Middle M Last Ludwick | | | | 4. DATE OF DEATH 5/8/57 Month 5 Day 8 Year 19 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 4/5/90 | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 6 Days 15 | | IF UNDER 24 HRS. Hours 15 Min. 00 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Butler, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Ludwick | | | | 14. MOTHER'S MAIDEN NAME McConnell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. WW #1 | | 17. INFORMANT Mr. Ken P. Allen, Cedar Lane, Ednor, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/9/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 5/11/57 | | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR 5-10-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Estelle B. Lanier | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---------------------------------------|--|
| Name of Deceased MONTANA, DO. JEN | | Sex F | | Age 21 | |
| Date of Death MAY 17 1957 | | Place of Death BOSTON, MASS. | | Cause of Death CORONARY THROMBOSIS | |
| Occupation Nurse | | Residence 1000 BROADWAY, BOSTON, MASS. | | Medical History None | |
| Signature of Physician J. H. MONTANA | | Signature of Medical Examiner J. H. MONTANA | | Signature of Coroner J. H. MONTANA | |

BUREAU V. 81

MAY 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05367
Reg. Dist. No. 215

| | | | | | | | | |
|--|----------------------------------|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | c. LENGTH OF STAY IN 1b DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12818 Evanston Street | | | | /d. STREET ADDRESS 12816 Evanston Street | | | | |
| 3. NAME OF DECEASED (Type or print) First Janet Middle Gail Last MATELLO | | | | 4. DATE OF DEATH Month May Day 29 Year 19 57 | | | | |
| 5. SEX F | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 22, 1955 | | 9. AGE (In years last birthday) 1 yrs. | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Richard F. MATELLO | | | | 14. MOTHER'S MAIDEN NAME Amy FRASER | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Richard F. MATELLO | | Address (Same as #2) | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) None Drowning (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Child drowned in bathtub at home | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child drowned in bathtub at home | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Rockville Montgomery Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) Frank J. BROSCART, M.D. | | | | DATE SIGNED May 29, 1957 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-3-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> ADDRESS Maryland R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, | | | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE <i>Mary E. Russell</i> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 3 1957

BUREAU V. 1

Form with multiple sections and fields, including a large circular stamp in the center. The text is mostly illegible due to the quality of the scan and the orientation of the document. Some visible text includes "BUREAU V. 1" and "JUN 3 1957".

05392

CERTIFICATE OF DEATH

Reg. Dist. No.

05308
05368
216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 4201 Massachusetts Avenue, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Cady Malchenson | | | | 4. DATE OF DEATH Month Day Year May 29 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 10, 1907 | |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Office Supplies | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Francis Winn | | | | 14. MOTHER'S MAIDEN NAME Clara Spear | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unascertainable | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast-Widespread Metastases 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 541.1 Duodenal ulcer-perforating; Dermatomyositis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 23, 1957 , to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 11:00p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 5/30/57 | | | | | | | |
| ACTUAL SIGNATURE John Laszlo PHYSICIAN'S NAME (Type) John Laszlo, M. D. | | | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc., Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR JUN 10 1957 24b. REGISTRAR'S SIGNATURE Beau Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05393

CERTIFICATE OF DEATH

05369

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Jefferson | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 8 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dillonvale | |
| d. NAME OF HOSPITAL (If not in hospital, give name of institution) The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS (None) 72X-3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thelma Middle May Last Malin | | | | 4. DATE OF DEATH Month May Day 11 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 31 March 1919 | |
| 9. AGE (In years last birthday) 38 yrs. | | IF UNDER 1 YEAR Months 1 Days 10 Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Henry Roberts | | | | 14. MOTHER'S MAIDEN NAME Maudie Propst | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 204.1 DUE TO Rupture of Spleen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelocytic Leukemia (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 3, 1957 , to May 11, 1957 , that I last saw the deceased alive on May 11, 1957 , and that death occurred at 3:55 A.M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | DATE SIGNED 5/11/57 | | | |
| ACTUAL SIGNATURE Arthur J. Garceau M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) ARTHUR J. GARCEAU, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/11/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Dillonvale | | 22d. LOCATION (City, town, or county) (State) Dillonvale Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. ADDRESS | | | | 24a. REC'D BY REGISTRAR 5-14-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Shoup | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

MAY 16 1957

RECEIVED

Robert A. Humphrey-1557 W. Ave. Bethesda, Md.

05370

MARYLAND

STATE DEPARTMENT OF HEALTH

05394

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Kensington</u> TOWN <u>Kensington</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Maryland</u> OR TOWN <u>Kensington, Maryland</u> STREET ADDRESS (If rural, give location) <u>10528 Wheatley Street</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Lucie</u> (First) <u>M</u> (Middle) <u>Marshall</u> (Last) | | 4. DATE OF DEATH <u>May 28</u> 1957 (Month) (Day) (Year) | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>10/20/1873</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 9. AGE last birthday <u>83</u> yrs. If under 1 year Months <u>7</u> Days <u>8</u> If under 24 hr Hours <u>8</u> Min |
| 11. BIRTHPLACE (State or foreign country) <u>New York City</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Alfred Voyer</u> | | 14. MOTHER'S MAIDEN NAME <u>Urainie Marchand</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT AND ADDRESS <u>Norman Smith, 10630 Wheatley St. Ken.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> Immediate cause (a) <u>Chronic Congestive Heart Failure</u> Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cerebral Thrombosis</u> | | | <u>3 yrs.</u> <u>6 da</u> |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION <u>332 X</u> | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 28, 1954</u> , to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 21, 1957</u> , and that death occurred at <u>5:50 a.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Robert J. Thibodeau, M.D.</u> (Degree or title) | | ADDRESS <u>Kensington, Md</u> DATE SIGNED <u>May 28, 57</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u> | | DATE <u>5/31/57</u> NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill</u> LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> | |
| DATE REC'D BY LOCAL REG. <u>5-29-57</u> REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u> ADDRESS | |

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 4 1957

RECEIVED

05395

CERTIFICATE OF DEATH

Reg. Dist. No.

211

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove | | c. LENGTH OF STAY IN 1b 10 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First GEORGIANA Middle MATHIAS Last | | 4. DATE OF DEATH Month MAY Day 5 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 18 1876 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME L. D. Shipe | | 14. MOTHER'S MAIDEN NAME Mathilda Cullers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) ##### | | 16. SOCIAL SECURITY NO. #### | |
| 17. INFORMANT Calvin Miller, Germantown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) XXXXXXXXXX | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis, severe; Diabetes mellitus; Osteoarthritis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/27 , 19 55 , to 5/5 , 19 57 , that I last saw the deceased alive on 5/5 , 19 57 , and that death occurred on 11:10 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gilcin F. Meadors M.D. | | ADDRESS (Street, city or town, state) Damascus, Maryland | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 8 1957 | 22c. NAME OF CEMETERY OR CREMATORY Flower Hill | 22d. LOCATION (City, town, or county) (State) Redland Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber | | ADDRESS Laytonsville, Md. | 24a. REC'D BY REGISTRAR DATE May 16/57 |
| | | 24b. REGISTRAR'S SIGNATURE Della W. Burdette | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05396

CERTIFICATE OF DEATH

Reg. Dist. No.

05372
274

| | | | | | | | |
|--|--|---------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1000 Helena Drive</u> | | | | d. STREET ADDRESS <u>1000 Helena Drive</u> 1 | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Matthews</u> Last <u>Matthews</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB. 21, 1886</u> 71 yrs. | |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>ROMANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>MARTIN SCHWARTZ</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EDITH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS. ROBERT WHITMAN</u> Address <u>SL. SPR. Md.</u> | | 8553 FENTON ST. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal failure</u> (c) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 mo.</u> <u>3 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan 30, 1955</u> to <u>MAY 13, 1957</u> , that I last saw the deceased alive on <u>MAY 13, 1957</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Raymond Bradshaw</u> | | | | ADDRESS (Street, city or town, state) <u>345 University Blvd, West Silver Spring, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u> | | | | DATE SIGNED <u>MAY 13, 1957</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 15, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sharon Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Rangaswamy + Ans - 3501 14th St. N.W., Wash., D.C.</u> | | | | 24a. REGISTERED REGISTRAR DATE <u>5/15/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u> | |

CERTIFICATE OF DEATH

Form No. 1

| | | | |
|---|--|--|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Age: <i>45</i></p> | | <p>4. Date of death: <i>May 15, 1957</i></p> | |
| <p>5. Place of death: <i>Home</i></p> | | <p>6. Cause of death: <i>Heart Disease</i></p> | |
| <p>7. Immediate cause: <i>Myocardial Infarction</i></p> | | <p>8. Underlying cause: <i>Coronary Artery Disease</i></p> | |
| <p>9. Contributing cause: <i>None</i></p> | | <p>10. Manner of death: <i>Natural</i></p> | |
| <p>11. Signature of physician: <i>Dr. J. Smith</i></p> | | <p>12. Signature of registrar: <i>John Doe</i></p> | |
| <p>13. Date of registration: <i>May 20, 1957</i></p> | | <p>14. Office of registration: <i>Bureau V. 1</i></p> | |

BUREAU V. 1

MAY 20 1957

RECEIVED

05397

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47 X-3</u> | | | |
| c. LENGTH OF STAY IN 1b <u>4 Days</u> | | | | d. STREET ADDRESS <u>20 3rd St., N.E.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Raymond</u> Last <u>MC CARTHY</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>14 Nov. 1909</u> | 9. AGE (In years last birthday) <u>47</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Senator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u> | | 11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Timothy Mc Carthy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bridget Tierney</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 8-12-42 to 2-20-45</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Official Navy Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatitis, acute, cause unknown</u> 580X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>28 April</u> , 19 <u>57</u> , to <u>2 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 May</u> , 19 <u>57</u> , and that death occurred at <u>6:02 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>5-2-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>C. U. Shilling</u> | | | | M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>C. U. SHILLING, LT. JG. USN</u> | | | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-9-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Appleton, Wisconsin</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulson</u> | | | | ADDRESS <u>1756 B. Ave N.W. D.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-3-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 6 1957

RECEIVED

05398

CERTIFICATE OF DEATH

Reg. Dist. No.

05374 216

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b 7 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| 3. NAME OF DECEASED (Type or print) First Lottie Middle Frances Last McDuffie | | 4. DATE OF DEATH Month May Day 15 , Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 19, 1892 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman | | 10b. KIND OF BUSINESS OR INDUSTRY Salesmanship | 11. BIRTHPLACE (State or foreign country) Virginia |
| 13. FATHER'S NAME Charles Martin | | 14. MOTHER'S MAIDEN NAME Julia Clingingpeel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-34-2286 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, HYponATREMIA DUE TO (c) MULTIPLE MYELOMA | | | INTERVAL BETWEEN ONSET AND DEATH 5 HRS. 5 HRS. 11 Mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 8 , 19 57 , to May 15 , 19 57 , that I last saw the deceased alive on May 15 , 19 57 , and that death occurred at 9:00 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Gurston Goldin</i> | | DATE SIGNED 5/15/57 | |
| PHYSICIAN'S NAME (Type) Gurston Goldin, M. D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-18-57 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d. LOCATION (City, town, or county) (State) Suitland Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. | | 24a. REC'D BY REGISTRAR 1661- Wood Hope Rd SE WASH. D.C. | 24b. REGISTRAR'S SIGNATURE DATE 5/17/57 <i>Bessie Thompson</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 05375 | |
|--|--|-------------------------------|--|--|--|--------------------------------------|---|--|--|--|--|
| 05399 | | | | | | | | | | CERTIFICATE OF DEATH | |
| | | | | | | | | | | Reg. Dist. No. 217 | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Wray</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | | c. LENGTH OF STAY IN 1b <u>3 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83X-3</u> | | | | |
| d. NAME OF HOSPITAL (If not hospital, give street address or institution) <u>Sharon Chronic Hospital</u> | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>C.</u> Last <u>McKeand</u> | | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1957</u> | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 4, 1864</u> | | 9. AGE (In years last birthday) <u>92</u> yrs. | | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horsewife Nurse</u> | | | | | 11b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>Newburgh Ontario</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Allen Caton</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Anne Price</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Hosp Record</u> Address <u></u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest - Ren. Sensitivity</u> DUE TO <u>902.7</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis, Stenosis atherosclerosis</u> DUE TO <u>10 days</u> (c) <u>Fract Femur - Test - Plate</u> DUE TO <u>10 days</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell out of bed and sustained fract. & open reduction required</u> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3</u> p.m. <u>4-10-57</u> 19 | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u> | | 20f. (City or town) <u>Olney</u> (County) <u>Montg.</u> (State) <u>Md.</u> | | |
| 21. I certify that I attended the deceased from <u>6-1-1954</u> , to <u>5-12-1957</u> , that I last saw the deceased alive on <u>11 May</u> , 19 <u>57</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John B Ziegler</u> M.D. | | | | | ADDRESS (Street, city or town, state) <u>OLNEY MD</u> | | | | | | |
| PHYSICIAN'S NAME (Type) <u>J.B. ZIEGLER</u> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 22b. DATE THEREOF <u>MAY 14 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LAYTONSVILLE MD</u> | | 22d. LOCATION (City, town, or county) <u>Montgomery Md</u> (State) <u>Md</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W BARBER</u> | | | | | ADDRESS <u>LAYTONSVILLE MD</u> | | 24a. REC'D BY REGISTRAR <u>DATE 5-16-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u> | | |

most prominent

Virginia

W. H. H. H.

Sharon Chronic Hospital

Flora C. McKeon

Dec. 4, 1884

Female White

Housewife & Nurse

Allen Cotton

Charlotte Anne Price

Newbury Cottage

Hosp. Record -

BUREAU V. H.

Nov 22 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

.05400 CERTIFICATE OF DEATH

05376

Reg. Dist. No. 210-216

| | | | | | |
|--|------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>9 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | d. STREET ADDRESS <u>15321 Glenwood Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Edybeth</u> Middle <u>Porterfield</u> Last <u>McNabb</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u> | | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-22-86</u> | 9. AGE (In years, last birthday) <u>70</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Tenn</u> | |
| 13. FATHER'S NAME <u>Frank Elliott</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hospt. records</u> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to Coronary Thrombosis -</u> DUE TO (c) <u>coronary heart disease</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 19, 1957</u> , that I last saw the deceased alive on <u>May 18, 1957</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Sidney E Cousins</u> M.D. <u>3921 Luganor X 200 5/19/57</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u> <u>2146 80</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 22b. DATE THEREOF <u>5/21/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | |
| | | | | 22d. LOCATION (City, town, or county) (State) <u>Nashville, Tennessee</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.,</u> | | | 24a. REC'D BY REGISTRAR DATE <u>5/22/57</u> | | |
| ADDRESS <u>2901 14th St., N.W.</u> <u>Washington, D.C.</u> | | | 24b. REGISTRAR'S SIGNATURE <u>Mary Layton</u> <u>Bessie Thompson</u> | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

HAD ANY

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BUREAU V. 1

MAY 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05401

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05377

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 2 hr. 45 min. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbridge | |
| 3. NAME OF DECEASED (Type or print) First Michael Middle Joseph Last MC NALLY | | 4. DATE OF DEATH Month May Day 24 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 May 1953 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 3 | 11. IF UNDER 24 HRS. Hours 3 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Richard J. MC NALLY | | 14. MOTHER'S MAIDEN NAME Florence Taylor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT (Father) Richard J. MC NALLY (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage and laceration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Compound, Multiple Fractures of skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child ran in rear of carbacking out of driveway when struck 20c. TIME OF INJURY Month, Day, Year Hour 8:55 P. M. May 23 1957 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Woodbridge Virginia | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Dr. Frank J. Broschart, MD | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 24 May 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-29-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE David H. Stoll | | ADDRESS Arlington, Va. | |
| Fitzgerald Funeral Home, 3245 Wilson Blvd. | | 24a. REC'D BY REGISTRAR DATE 5-24-57 | |
| 24b. REGISTRAR'S SIGNATURE Mary S. Parrelly | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | |
| John Doe | | 45 | | Male | | White | |
| Date of Death | | Place of Death | | Cause of Death | | Manner of Death | |
| May 20, 1957 | | Home | | Heart Disease | | Natural | |
| Signature of Examiner | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 3

MAY 27 1957

RECEIVED

CERTIFICATE OF DEATH

05378

Reg. Dist. No. 214

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u> | | | | d. STREET ADDRESS <u>625 Sheridan St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Mendelson</u> Last <u></u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>w</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/31/1911</u> | |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washing D.C. Poland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME <u>Jeremiah Weitz</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Bella</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>Benj. Mendelson</u> Address <u>Chillum, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF CERVIX</u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 mon's</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>57</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James C. Weiner</u> | | | | DATE SIGNED <u>100 Longfellow St. N.W.</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 5, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langford</u> | | | | ADDRESS <u>3501-14 St. NW D.C.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 5-7-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bernard M. Thompson</u> | | | | | | | |

CERTIFICATE OF DEATH

Form 10-1-54

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED <i>JOHN J. BROWN</i> | | 2. SEX <i>M</i> | | 3. AGE <i>68</i> | |
| 4. PLACE OF BIRTH <i>NEW YORK, N.Y.</i> | | 5. DATE OF BIRTH <i>1889</i> | | 6. PLACE OF DEATH <i>BALTIMORE, MD.</i> | |
| 7. OCCUPATION <i>RETIRED</i> | | 8. CAUSE OF DEATH <i>HEART DISEASE</i> | | 9. MANNER OF DEATH <i>NATURAL</i> | |
| 10. SIGNATURE OF PHYSICIAN <i>J. H. SMITH</i> | | 11. SIGNATURE OF REGISTRAR <i>W. J. BROWN</i> | | 12. SIGNATURE OF WITNESSES <i>J. H. SMITH, W. J. BROWN</i> | |
| 13. DATE OF DEATH <i>MAY 10, 1957</i> | | 14. TIME OF DEATH <i>10:00 AM</i> | | 15. PLACE OF INTERMENT <i>CATHOLIC CEMETERY</i> | |
| 16. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 17. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 18. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 19. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 20. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 21. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 22. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 23. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 24. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 25. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 26. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 27. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 28. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 29. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 30. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 31. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 32. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 33. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 34. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 35. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 36. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 37. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 38. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 39. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 40. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 41. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 42. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 43. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 44. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 45. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 46. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 47. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 48. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 49. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 50. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 51. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 52. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 53. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 54. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 55. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 56. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 57. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 58. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 59. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 60. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 61. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 62. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 63. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 64. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 65. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 66. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 67. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 68. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 69. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 70. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 71. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 72. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 73. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 74. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 75. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 76. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 77. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 78. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 79. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 80. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 81. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 82. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 83. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 84. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 85. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 86. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 87. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 88. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 89. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 90. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 91. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 92. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 93. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 94. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 95. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 96. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 97. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 98. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 99. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |
| 100. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 101. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | | 102. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i> | |

BUREAU V. 2

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05300 CERTIFICATE OF DEATH

05379

Reg. Dist. No. 223

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2 ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u> | | d. STREET ADDRESS <u>1801 Drexel Street</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Meredith</u> | | 4. DATE OF DEATH Month Day Year <u>May 18 1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 29-1889</u> 67 yrs. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Machine Worker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna</u> | |
| 13. FATHER'S NAME <u>John H. Meredith</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Mann</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Uremia</u> DUE TO <u>24 HRS</u> (c) <u>MARKED GENERALIZED ARTERIOSCLEROSIS</u> <u>7 YEARS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>18 HRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>FEB 14</u> , 19 <u>55</u> , to <u>MAY 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 18</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1352-4 UNIVERSITY RD</u> DATE SIGNED <u>HAROLD STERLING</u> | | | |
| ACTUAL SIGNATURE <u>HAROLD STERLING</u> | | M.D. <u>1352-4 UNIVERSITY RD</u> | |
| PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u> | | <u>HYATTSVILLE MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u> | 22b. DATE THEREOF <u>5/21/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Altoona</u> | 22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>5/31/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05402

CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanatown</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanatown</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Jane</i> Last <i>Metz</i> | | | | 4. DATE OF DEATH Month <i>May</i> - Day <i>3</i> - Year <i>1957</i> | | | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Dec. 17-1893</i> | |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping</i> | | 11. BIRTHPLACE (State or foreign country) <i>Germanatown, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Edward Perrell</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Lillie A. Page</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>220-16-0257</i> | | 17. INFORMANT <i>William F. Metz, Germanatown, Md.</i> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of sigmoid</i> <i>153X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>?</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X Diabetes Mellitus</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <i>Feb-2-</i> , 1957, to <i>May-3-</i> , 1957, that I last saw the deceased alive on <i>May-2-</i> , 1957, and that death occurred at <i>3:30 A.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7-Brooks avenue Gaithersburg, Md.</i> DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>William C. Miller</i> M.D. | | | | PHYSICIAN'S NAME (Type) <i>William C. Miller</i> <i>Gaithersburg, Md.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>May-3-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Baptist Church Cemetery. Germanatown. Md.</i> | | 22d. LOCATION (City, town, or county) _____ (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gartner.</i> ADDRESS <i>Gaithersburg. Md.</i> | | | | 24a. REC'D BY REGISTRAR <i>May 6-57</i> | | 24b. REGISTRAR'S SIGNATURE <i>Abner L. Coode</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be submitted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Montgomery

23

at home

Montgomery

June

Montgomery

May - 3 - 07

June 17-1893

June 17-1893

June 17-1893

June 17-1893

June 17-1893

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June 17-1893

June 17-1893

William C. Miner

William C. Miner

William C. Miner

William C. Miner

William C. Miner

BUREAU V. 5

MAY 10 1957

RECEIVED

William C. Miner

William C. Miner

05403

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>3700 Mass. Ave. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>B</u> Last <u>Mintener</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 29, 1877</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Northern Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John William Bradshaw</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Balfour</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Bradshaw Mintener</u> | | Address <u>Wash. D.C. 4755 Berkeley Terrace</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>2 yrs. +</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Karl Dortzbach</u> M.D. | | ADDRESS (Street, city or town, state) <u>Washington Clinic</u> DATE SIGNED <u>3/3/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Karl Dortzbach M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 22b. DATE THEREOF <u>5/3/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Minneapolis, Minnesota</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Kines Co.</u> ADDRESS <u>2901-14th St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u>5/7/57</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05404

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Prince William | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 12 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS (No street address) | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Virginia | | First Virginia Middle (None) Last Morgan | | 4. DATE OF DEATH Month May Day 3 Year 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 17 March 1907 | |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Madison Byers | | | | 14. MOTHER'S MAIDEN NAME Lizzie Gantley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I° | | | | 16. SOCIAL SECURITY NO. --- | | | |
| 17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma uterine cervix 171X DUE TO Extension of carcinoma to uterine artery Holder, uterine pedicle - metastatic to liver DUE TO acute & moderate bronchopneumonia DUE TO Bilateral hydrocephalus & hydrothorax Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 21, 1957 , to May 3, 1957 , that I last saw the deceased alive on May 3, 1957 , and that death occurred at 1.53A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Peter B. H'Doubler M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/3/57 | | | |
| PHYSICIAN'S NAME (Type) Peter B. H'Doubler, M.D. | | | | National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Stonewood | | 22d. LOCATION (City, town, or county) (State) Prayer MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home Fairfax Va | | | | 24a. REC'D BY REGISTRAR DATE 5-6-57 | | 24b. REGISTRAR'S SIGNATURE Bessie H. Harrison | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 7 1957

BUREAU V. 2

05405

CERTIFICATE OF DEATH

05383

Reg. Dist. No. 275246

| | | | | | | | |
|--|----------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 1014 Columbia Road, N. W. | | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Clifton Last Moten | | | | 4. DATE OF DEATH Month May Day 10 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 14, 1892 | | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Charles Moten | | | | 14. MOTHER'S MAIDEN NAME Daisy Jackson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Cachexia 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastasis DUE TO (c) Carcinoma of the esophagus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) 581.0 Cirrhosis of liver | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 9 , 19 57 , to May 10 , 19 57 , that I last saw the deceased alive on May 10 , 19 57 , and that death occurred at 4:40 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center Bethesda 14, Maryland 5/11/57 | | | | | | | |
| ACTUAL SIGNATURE James R. Jude | | | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) JAMES R. JUDE, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial | | 22d. LOCATION (City, town, or county) (State) Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ray S.P. Morrow | | | | ADDRESS 1622 11th St., N.W. Wash. 1. D.C. | | 24a. REC'D BY REGISTRAR DATE 5/13/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1912 | |
| Place of Birth | | Cause of Death | | Date of Death | | Time of Death | |
| New York City | | Heart Disease | | Jan 15, 1957 | | 10:30 AM | |
| Occupation | | Signature of Physician | | Signature of Registrar | | Signature of Informant | |
| Teacher | | [Signature] | | [Signature] | | [Signature] | |
| Manner of Death | | Place of Death | | Date of Burial | | Time of Burial | |
| Natural | | Home | | Jan 18, 1957 | | 12:00 PM | |

BUREAU V. 1

MAY 14 1957

RECEIVED

05301

CERTIFICATE OF DEATH

05384

Reg. Dist. No.

223

| | | | | | | | |
|--|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | e. STREET ADDRESS <u>3317 Floral Court</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant Boy Muller</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 19 1957</u> | | | |
| 5. SEX <u>Boy</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 19 1957</u> | 9. AGE (In years last birthday) yrs. <u>11</u> | IF UNDER 1 YEAR Months Days Hours Min. <u>11 26</u> | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles James Muller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Mae Colie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mother 3317 Floral Court, Silver Sp.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>5-19-57</u> , <u>19</u> , and that death occurred at <u>10:50p</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Herbert H. Diamond</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>8224 - Ga. Ave. S.E. 5/22/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Herbert H. Diamond</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>5-20-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Hare, M. D. Wash. San. & Hosp. T.P.Md.</u> | | | | 24. REC'D BY REGISTRAR <u>9-1957</u> | | 25. REGISTRAR'S SIGNATURE <u>John R. Dodt</u> | |

2075264xv2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

10 OF NOV

RECEIVED

05496

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN IB 9 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Agnes Middle Regina Last Murtaugh | | 4. DATE OF DEATH Month May Day 7 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 13, 1883 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic - house work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Luke E. Murtaugh | | 14. MOTHER'S MAIDEN NAME Bridgett Agnes Gillen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none | | 17. INFORMANT Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of mesentery of small bowel - primary site unknown DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized osteo-arthritis with ankylosis of knees & elbows | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 29, 19 57 to May 7, 19 57 , that I last saw the deceased alive on May 7, 19 57 , and that death occurred at 10:40 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur F. Woodward | | ADDRESS (Street, city or town, state) Rockville, Md. | |
| PHYSICIAN'S NAME (Type) A. F. Woodward, M. D. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/10/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey | | 24. REC'D BY REGISTRAR 5-9-57 | |
| ADDRESS SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE Gertrude B. Jarrow | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05407

Reg. Dist. No. 05386

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg rfd | | c. LENGTH OF STAY IN 1b 2 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Gaithersburg RFD | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Route 240 | | | | d. STREET ADDRESS 1 U.S. Route 240 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Neal Jr. | | | | 4. DATE OF DEATH Month Day Year May 24, 1957 19 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/2/32 | | 9. AGE (In years last birthday) 24 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Forestry | | 11. BIRTHPLACE (State or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph W. Neal | | | | 14. MOTHER'S MAIDEN NAME Bessie D. Berry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Diane Mae Neal (Same as Item 2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Laceration 976X DUE TO Bullet wound thru skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 5/24/57 19 p. m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Auto | | 20f. (City or town) (County) (State) Gaithersburg Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-28-57 | | 22c. NAME OF CEMETERY OR CREMATORY Clifton Cemetery | | 22d. LOCATION (City, town, or county) (State) Clifton Texas | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner | | | | ADDRESS Gaithersburg, Md. | | 24a. REC'D BY REGISTRAR May 27-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Abraham L. Cook | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

05408

CERTIFICATE OF DEATH

05387

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 51 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Isabel Middle Kyle Last Neely | | | | 4. DATE OF DEATH Month May Day 19 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 15, 1907 | |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min. | | IF UNDER 24 HRS. Months 4 Days 19 Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editorial Assistant | | | | 10b. KIND OF BUSINESS OR INDUSTRY Medical Journalism | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Neely | | | | 14. MOTHER'S MAIDEN NAME Florence Kyle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 578-01-5260 | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL METASTASES 170X DUE TO CARCINOMA OF BREAST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST DUE TO (c) CARCINOMA OF BREAST | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET OF DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March 29 , 19 57 , to May 19 , 19 57 , that I last saw the deceased alive on May 19 , 19 57 , and that death occurred at 3:40 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/19/57 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND | | | | | | | |
| ACTUAL SIGNATURE Gurston D. Goldin M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Gurston D. Goldin, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/23/57 | | 22c. NAME OF CEMETERY OR CREMATORY Uniondale Cemt. | | 22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Birchia's Son ADDRESS Wash., 3034 M St. N.W. D.C. | | | | 24a. REC'D BY REGISTRAR DATE 5-21-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 23 1957

RECEIVED

1
 M
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 05409
 CERTIFICATE OF DEATH

05388

Reg. Dist. No. 217

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brighton</u> | | c. LENGTH OF STAY IN 1b <u>89</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>none</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brighton</u> | |
| | | d. STREET ADDRESS <u>none</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Elizabeth</u> Middle <u>Hugent</u> Last | | 4. DATE OF DEATH <u>May</u> Month <u>9</u> Day <u>9</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 29 1966</u> 9. AGE (In years last birthday) <u>91</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.H</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.H</u> | |
| 13. FATHER'S NAME <u>Charles Holland</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Bacon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs Maudie Hill</u> Address <u>Brighton Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cc. Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>151X</u> DUE TO (c) <u>151X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1950</u> ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X Hypertensive Cardiv-Vascular Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>March, 1948</u> to <u>5-8-</u> 19 <u>57</u> that I last saw the deceased alive on <u>5-8-</u> 19 <u>57</u> , and that death occurred at <u>6:30</u> A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Calvin B. LeCompte</u> M.D. <u>61 R St. NE</u> | | DATE SIGNED <u>May 9, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Calvin B. LeCompte</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/11/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u> | 22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Snowden</u> ADDRESS <u>Rookville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>5/15/57</u> | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u> |

MAY 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05410

CERTIFICATE OF DEATH

Reg. Dist. No.

05389
217

| | | | |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring RFD # 1</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Silver Spring RFD # 1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Norbeck - Norwood Rd.</u> | | d. STREET ADDRESS <u>Norbeck - Norwood Rd.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Victoria</u> Middle <u>O'CONNELL</u> Last | | 4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 23, 1896</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JEFFERY C. O'CONNELL</u> | | 14. MOTHER'S MAIDEN NAME <u>Eleanor Costello</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Ann L O'CONNELL</u> Address <u>Silver Spring RFD # 1</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>Yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5/28</u> , 19 <u>57</u> , to <u>5/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/28</u> , 19 <u>57</u> , and that death occurred at <u>12:05 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. H. L. IGIN.</u> | | ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>5/28/57</u> | |
| PHYSICIAN'S NAME (Type) <u>C. H. L. IGIN.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 1</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber, Laytonville, Md.</u> | | 24. REC'D BY REGISTRAR DATE <u>6-1-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u> | | | |

BUREAU V. S.

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05390

05411

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Etchison | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Etchison | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Life | | | | d. STREET ADDRESS Rfd#2 Gaithersburg, Md. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Thomas (None) Owings | | | | 4. DATE OF DEATH Month Day Year May 26 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 11, 1881 | | 9. AGE (In years last birthday) yrs. 76 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Levin I.G. Owings | | | | 14. MOTHER'S MAIDEN NAME Maria Dorsey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-38-0139 | | 17. INFORMANT Gaithersburg, Md. Mrs. Elizabeth Owings, Rfd 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchiectases DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 years 3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 526X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. ft. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 3/11 , 19 52 , to 5/26 , 19 57 , that I last saw the deceased alive on 5/25 , 19 57 , and that death occurred at 11:01 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | M.D. Santaghi DATE SIGNED 5/28/57 | | | |
| PHYSICIAN'S NAME (Type) Dr. J. W. Bird | | | | Olney, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth. | | 22d. LOCATION (City, town, or county) (State) Laytonsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Royce Barber | | | | ADDRESS Cemetery Laytonsville, Md. | | 24a. REC'D BY REGISTRAR DATE 6-1-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE [Signature] | | | |

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05412

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River 18 X 22</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | d. STREET ADDRESS <u>U.S. Naval Air Station</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Roy</u> Last <u>PANTANO</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>18 August 1956</u> | | 9. AGE (In years last birthday) yrs. <u>8</u> | IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> | IF UNDER 24 HRS. Hours <u>8</u> Min. <u>19</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James Joseph Pantano</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Vivian Parker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>(Father) James J. Pantano, (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYDROCEPHALUS</u> DUE TO (c) <u>HEMINGO MYELOCELE</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>19</u> o. m. <u>p. m.</u> | Month <u>19</u> | Day <u>19</u> | Year <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10 April</u> , 19 <u>57</u> , to <u>6 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 May</u> , 19 <u>57</u> , and that death occurred at <u>8:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 5-8-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Daniel Shuptar</u> | | | | PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>5-9-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Little Flower Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Great Mills, Maryland</u> | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robinson Funeral Home, Leonardtown, Md.</u> | | | | ADDRESS <u>Robinson Funeral Home, Leonardtown, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-7-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05392

05413

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Indian Spring Drive | | d. STREET ADDRESS /105 Indian Spring Drive | |
| 3. NAME OF DECEASED (Type or print) First William Middle Park Last Park | | 4. DATE OF DEATH Month May Day 12 Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/15/82 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months 6 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Park Transfer Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Scotland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Park | | 14. MOTHER'S MAIDEN NAME Jane Annand | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 | | 16. SOCIAL SECURITY NO. 434.1 | |
| 17. INFORMANT William A. Park | | Address 110 Dale Drive S.S. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) 5 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour 19 o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 1956 to 12 MAY 1957 that I last saw the deceased alive on 12 MAY 1957 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L.B. Snow | | M.D. 9013 FLOWER AVE. SILVER SPRING, MD. | |
| PHYSICIAN'S NAME (Type) 5/12/57 | | DATE SIGNED 5/12/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 5/15/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State) Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE 5/14/57 | |
| 24b. REGISTRAR'S SIGNATURE Frances Pottel | | DATE 5/14/57 | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | |
|------------------------------------|--|-------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| PLACE OF BIRTH [Illegible] | | DATE OF BIRTH [Illegible] | | TIME OF BIRTH [Illegible] | |
| OCCUPATION [Illegible] | | CAUSE OF DEATH [Illegible] | | MANNER OF DEATH [Illegible] | |
| PLACE OF DEATH [Illegible] | | DATE OF DEATH [Illegible] | | TIME OF DEATH [Illegible] | |
| NAME OF PHYSICIAN [Illegible] | | NAME OF FUNERAL HOME [Illegible] | | NAME OF BURIAL PLACE [Illegible] | |
| NAME OF NEXT OF KIN [Illegible] | | NAME OF MINISTER [Illegible] | | NAME OF CHURCH [Illegible] | |
| NAME OF CEMETERY [Illegible] | | NAME OF INTERVIEWER [Illegible] | | NAME OF REGISTRAR [Illegible] | |
| NAME OF CORONER [Illegible] | | NAME OF JURY [Illegible] | | NAME OF JUDGE [Illegible] | |
| NAME OF CLERK [Illegible] | | NAME OF Scribe [Illegible] | | NAME OF Notary [Illegible] | |

BUREAU W. B.

24 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05393

05414

CERTIFICATE OF DEATH

Reg. Dist. No. 211

| | | | | | | | |
|---|---|---|---|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg c. LENGTH OF STAY IN 1b 1 yr. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg X2 d. STREET ADDRESS 1 | | | |
| 3. NAME OF DECEASED (Type or print) Edward Thurber Paxton | | | | 4. DATE OF DEATH Month May Day 27 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 26, 1892 | | 9. AGE (In years lost birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Fed. Housing | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Milton Paxton | | | | 14. MOTHER'S MAIDEN NAME Mary Jane Boyle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Mrs. James Burdette, Clarksburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of face with generalized metastases DUE TO 191X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) metastases DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 5, 1956 , to May 27, 1957 , that I last saw the deceased alive on May 10, 1957 , and that death occurred at 2:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE James P. Kerr M.D. | | | | PHYSICIAN'S NAME (Type) Dr. J. P. Kerr Damascus, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Removal | | May 27 | | St. Lawrence | | Prince George, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber, Laytonville, Md. | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| | | | | DATE May 28/57 | | della N. Burdette | |

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05394

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11705 Idlewood Rd</u> | | d. STREET ADDRESS <u>11705 Idlewood Rd</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Fredrick</u> Last <u>Pergal</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-4-1915</u> |
| 9. AGE (In years last birthday) <u>41</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DC Police</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Pergal</u> | | 14. MOTHER'S MAIDEN NAME <u>FREDA PERGAL</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Maxine Pergal (wife)</u> | |
| 17. INFORMANT <u>Maxine Pergal (wife)</u> | | Address <u>2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bullet wound thru skull</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>976X</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a. m. <u>3</u> p. m. <u>1957</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>Home</u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Silver Spring Montg Md</u> (County) <u>Montg</u> (State) <u>Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5/7/1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u> | | 22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) <u></u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSO</u> | | ADDRESS <u>1300 N. STREET, N.W. - WASH. D.C.</u> | |
| 24a. REC'D BY REGISTRAR <u>6</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u> | |

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several columns and rows, with checkboxes for various conditions and symptoms.

RECEIVED
MAY 6 1957
BUREAU V. 3

05416

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 361 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Olefs Middle Edvins Last Plavnieks | | | | 4. DATE OF DEATH Month May Day 28 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 18, 1951 | |
| 9. AGE (In years last birthday) 5 yrs. | | IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Wash., D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME V. Richards Plavnieks | | 14. MOTHER'S MAIDEN NAME Irene Abols | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis and Pneumonia 710.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Dermatomyositis DUE TO (c) 1 1/2 yr. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493 X | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 1 , 19 56 , to May 28 , 19 57 , that I last saw the deceased alive on May 28 , 19 57 , and that death occurred at 5:55 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/29/57 | | | | | | | |
| ACTUAL SIGNATURE K. Lemone Yielding M.D. | | | | PHYSICIAN'S NAME (Type) K. Lemone Yielding | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 6/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Washington, D.C. | | | | 24a. REC'D BY REGISTRAR DATE 5-31-57 | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Abner E. Humphrey | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUN 4 1957

RECEIVED

05417 CERTIFICATE OF DEATH

Reg. Dist. No.

7 X3

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sant Hosp</u> | | | | d. STREET ADDRESS <u>9609 Bristol Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>May</u> Last <u>Poggioli</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1957</u> | | | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/6/1907</u> | 9. AGE (In years last birthday) <u>49</u> yrs. | IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Frederick Hardy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susie Steele</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Hosp records</u> | | 17. INFORMANT Address <u>Hosp records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Lesion</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage from Varicella</u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs.</u> <u>10 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from <u>Jan 4</u> , 1954, to <u>May 7</u> , 1957, that I last saw the deceased alive on <u>May 7</u> , 1957, and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W.B. Wardrop</u> | | | | ADDRESS (Street, city or town, state) <u>837 Bonifant St Silver Spring, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W.B. Wardrop, MD</u> | | | | DATE SIGNED <u>5/7/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5-10-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEM.</u> | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Neponce</u> | | | | 24a. REC'D BY REGISTRAR <u>J. Thelma Addis</u> | | | |
| ADDRESS <u>1300-18th NW</u> | | | | DATE <u>5/10/57</u> | | | |
| WASHINGTON, D.C. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Case No. 10

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | |
| 4. DATE OF BIRTH [Faint text] | | 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | |
| 7. DATE OF DEATH [Faint text] | | 8. PLACE OF DEATH [Faint text] | | 9. CAUSE OF DEATH [Faint text] | |
| 10. MEDICAL HISTORY [Faint text] | | 11. HISTORY OF PRESENT ILLNESS [Faint text] | | 12. HISTORY OF PREVIOUS ILLNESSES [Faint text] | |
| 13. SIGNATURE OF PHYSICIAN [Faint text] | | 14. SIGNATURE OF REGISTRAR [Faint text] | | 15. SIGNATURE OF WITNESS [Faint text] | |

BUREAU V. 3

MAY 10 1957

RECEIVED

Master's Report to State Dept. of Health

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05418

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05397

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo | | c. LENGTH OF STAY IN 1b appr. 5 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓ | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McArthur Blvd | | | | d. STREET ADDRESS 3653 Minnesota Ave. S. E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sr. John Howard POLLET | | | | 4. DATE OF DEATH Month Day Year May 29 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Oct. 19, 1893 | |
| 9. AGE (In years and birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Concrete Op. | | 10b. KIND OF BUSINESS OR INDUSTRY Cramer Construc. | | 11. BIRTHPLACE (State or foreign country) Milwaukee, Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-18-7464 | | 17. INFORMANT John H. Pollet, Jr. Address 4330 Duke St. Alexandria, Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | 22b. DATE THEREOF 5-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY W. W. Chambers | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey | | | | ADDRESS 7557 White Ave. | | 24a. REC'D BY REGISTRAR JUN 3 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE R. H. Sedwick | | DATE SIGNED May 29, 1957 | |
| 22d. LOCATION (City, town, or county) Washington | | | | D. C. (State) | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|-------------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | |
| John Howard | | Male | | 35 | |
| Date of Death | | Place of Death | | Cause of Death | |
| May 20, 1957 | | Home | | Heart Failure | |
| Time of Death | | Manner of Death | | Occupation | |
| 10:00 PM | | Natural | | Physician | |
| Signature of Physician | | Signature of Medical Examiner | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

JUN 3 1957

RECEIVED

THOMAS M. BLOOMER, M.D.
W. W. OBERSTE

05419

CERTIFICATE OF DEATH

05398

Reg. Dist. No. 218

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg - Route 1</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Burnham Road</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Norris</i> Last <i>Prather</i> | | 4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1957</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>colored</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Oct. 13-1874</i> |
| 9. AGE (In years last birthday) <i>82</i> yrs. | | IF UNDER 1 YEAR Months <i>8</i> Days <i>20</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Laytonville, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Wesley Prather</i> | | 14. MOTHER'S MAIDEN NAME <i>Alice Dickinson</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>no</i> | |
| 17. INFORMANT <i>Katie Emma Prather</i> Address <i>Gaithersburg, Md.</i> | | R-1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] * PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myocardial degeneration</i> (c) <i>Senility</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>10-15 minutes</i> <i>3 years</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>April - 26 - 1957</i> , to <i>May - 3 - 1957</i> , that I last saw the deceased alive on <i>April - 26 - 1957</i> , and that death occurred at <i>12 P.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>William C. Miller</i> M.D. | | ADDRESS (Street, city or town, state) <i>7-Brooks Ave Gaithersburg, Md</i> | |
| PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>MAY 6/1957</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>BROOK GROVE</i> | 22d. LOCATION (City, town, or county) (State) <i>Montgomery Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W. Barber</i> ADDRESS <i>Laytonville, Md</i> | | 24a. REC'D BY REGISTRAR <i>May 7-57</i> | 24b. REGISTRAR'S SIGNATURE <i>Charles L. Cook</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Decedent: *William C. Mixer*
 Date of Birth: *1874-13-13*
 Date of Death: *1957-05-03*
 Place of Birth: *St. Albans, Vt.*
 Cause of Death: *Acute heart failure*
 Duration of Illness: *3 weeks*
 Attending Physician: *Dr. C. H. Smith*
 Burial Place: *St. Albans, Vt.*
 Interment: *St. Albans, Vt.*

RECEIVED
 MAY 10 1957
 BUREAU V. S.
 William C. Mixer
 1874-13-13
 1957-05-03
 St. Albans, Vt.
 St. Albans, Vt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05420

CERTIFICATE OF DEATH

05399

Reg. Dist. No. 18

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. STATE <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLANDER REST HOME</u> | | | | d. STREET ADDRESS <u>GERMANTOWN</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>HILDA</u> <u>PRICE</u> | | | | 4. DATE OF DEATH Month Day Year <u>5</u> <u>14</u> <u>1957</u> | | | |
| 5. SEX <u>FEM</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-13-1892</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>MONTGOMERY CO.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13. FATHER'S NAME <u>NATHAN KINNA</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JANE PICKENS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>RAYMOND P. PRICE HYATTSTOWN MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon with generalized metastasis</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Feb 14</u> , 19 <u>56</u> , to <u>May 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James P. Kinn</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Hyattstown, Md.</u> DATE SIGNED <u>5/15/57</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>5-17-1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>HYATTSTOWN METHODIST</u> | | 22d. LOCATION (City, town, or county) (State) <u>HYATTSTOWN MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Burdette</u> ADDRESS <u>Hyattstown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5/16/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alonzo Carver</u> | |

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05421

CERTIFICATE OF DEATH

05400

Reg. Dist. No. 215

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California 18x22</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | d. STREET ADDRESS <u>Millcove Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy PRUE</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 5 19 57</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4 May 1957</u> | |
| 9. AGE (In years last birthday) yrs. <u>17</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. <u>17 54</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | | |
| 13. FATHER'S NAME <u>Chester Devond Prue</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Christine Julia Baker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>(Father) Chester D. Prue (Same As #2)</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u> <u>770.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemolytic Disease of Newborn (Rh incompatibility)</u> DUE TO <u>Prematurity - 33 weeks</u> (c) <u>18 hours</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>774X</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>4 May</u> , 19 <u>57</u> , to <u>5 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 May</u> , 19 <u>57</u> , and that death occurred at <u>4:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>5-6-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>John H. Mazur</u> | | | | M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John H. Mazur, LT, MC, USN</u> | | | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-8-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> | | | | ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-6-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bary E. Parselly</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051254XV2

BUREAU V. E.

MAY 8 1957.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05401

05422

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hestoneland Hills Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Alexandria</u> | |
| c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> | | d. STREET ADDRESS <u>22 Bellfield Rd.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5408 Albemarle St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Blandine</u> Middle <u>Blandford</u> Last <u>Ramage</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 2 1869</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Joseph C. Ramage</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Hill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (a) or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs. Robert C. McCann</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>—</u> (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple strokes 2 yrs - congestive heart failure</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>H341</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1953</u> to <u>May 1957</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Jackson M. Carlow</u> M.D. | | ADDRESS (Street, city or town, state) <u>5404 Albemarle Wash DC</u> | |
| PHYSICIAN'S NAME (Type) <u>May 29 '57</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 31-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Alexandria Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Remaine Jr.</u> | | ADDRESS <u>Alex. Va.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 5-31-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Berrie M. Thompson</u> | |

CERTIFICATE OF DEATH

123456

| | | | |
|--|--|---|--|
| <p>1. Name of Deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of Birth: <i>Jan 1, 1900</i></p> | | <p>4. Date of Death: <i>Dec 1, 1957</i></p> | |
| <p>5. Place of Birth: <i>Baltimore, Md.</i></p> | | <p>6. Place of Death: <i>Baltimore, Md.</i></p> | |
| <p>7. Cause of Death: <i>Heart Disease</i></p> | | <p>8. Manner of Death: <i>Natural</i></p> | |
| <p>9. Signature of Physician: <i>Dr. J. K. Smith</i></p> | | <p>10. Signature of Registrar: <i>John Doe</i></p> | |
| <p>11. Date of Report: <i>Dec 1, 1957</i></p> | | <p>12. Office of Registrar: <i>Baltimore, Md.</i></p> | |

BUREAU V. 3

JUN 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 0540216 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b <u>6 1/2</u> hrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>X 2</u> | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>National Institute of Health</u> | | | | | d. STREET ADDRESS <u>8608 Brandt Place</u> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sheldon</u> <u>Edward</u> <u>Reaume</u> | | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u> | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>May 6, 1922</u> | | 9. AGE (In years last birthday) <u>35</u> yrs. | |
| | | | | | | | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | |
| | | | | | | | | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Micro biologist</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Mich.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown Reaume</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Emma M. ?</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>??</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u> | | 17. INFORMANT <u>Hospital Records</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyanide poisoning (suicide)</u> <u>971.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 6, 1957</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>5/16/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis.Ave.Bethesda Md.</u> | | | | | 24a. REC'D BY REGISTRAR <u>5/20/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Deputy Registrar</u> | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-------------------------------|--|--------------------------|--|------------------------|--|-------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| Occupation | | Education | | Medical History | | Post-mortem Examination | |
| Family History | | Social History | | Clinical History | | Gross Findings | |
| Microscopic Findings | | Bacteriological Findings | | Chemical Findings | | Other Findings | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| Date of Signature | | Date of Signature | | Date of Signature | | Date of Signature | |

BUREAU V. E.

MAY 20 1957

RECEIVED

05424 CERTIFICATE OF DEATH

05403

Reg. Dist. No. 215

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 4 mos. 21 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Benedict Last RIEDEL Jr. | | | | 4. DATE OF DEATH Month May Day 9 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 Feb. 1893 | | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | | 10b. KIND OF BUSINESS OR INDUSTRY Commercial | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Robert Benedict Riedel, Sr. | | | | 14. MOTHER'S MAIDEN NAME Euphasia Oswald | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW-I Unknown | | 17. INFORMANT (Son) Robert Benedict Riedel, III (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aortic stenosis and mitral insufficiency DUE TO (c) Rheumatic Heart Disease, Infective | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months 1-2 years 1-2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 416X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 17 Dec. , 19 56 , to 9 May , 19 57 , that I last saw the deceased alive on 9 May , 19 57 , and that death occurred at 7:13 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas R. Ulshafer M.D. U.S. Naval Hospital, Bethesda, Md. 5-10-57 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 5-13-57 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | | 22d. LOCATION (City, town, or county) (State) Johntown, Pennsylvania | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John P. ... | | | | 24a. REC'D BY REGISTRAR DATE 5-10-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V: M

MAY 13 1957

RECEIVED

05315

CERTIFICATE OF DEATH

Reg. Dist. No. 113

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Maryland Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) EZRA First ROYER Last | | | | 4. DATE OF DEATH Month May Day 15 , 1957 Year 19 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/29/69 | 9. AGE (In years last birthday) 87 yrs. | IF UNDER 1 YEAR Months 4 Days 18 | IF UNDER 1 YEAR Hours 18 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) Westminister, Maryland | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME John Royer | | | | 14. MOTHER'S MAIDEN NAME Martha Royer- Item # 2 | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-12-7579 | | 17. INFORMANT Address Martha Royer- Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Pneumia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis + chronic nephritis DUE TO 5 yrs. (c) none | | | | | | INTERVAL BETWEEN ONSET AND DEATH few days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1950 , 19 May 15 , 19 57 , that I last saw the deceased alive on May 15 , 19 57 , and that death occurred at 6:40 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wm. A. Linticium M.D. | | | | ADDRESS (Street, city or town, state) 26 N. Summit Ave. DATE SIGNED May 16, 1957 | | | |
| PHYSICIAN'S NAME (Type) Wm. A. Linticium | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/19/57 | | 22c. NAME OF CEMETERY OR CREMATORY Meadow Branch | | 22d. LOCATION (City, town, or county) (State) Westminister, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE 5/20/57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Laurel Prigmore | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

05425

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>13 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> <u>0210.2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u> | | | | d. STREET ADDRESS <u>901 Poplar Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Judy</u> Middle <u>FRANCINE</u> Last <u>ROYLANCE</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-24-43</u> | |
| 9. AGE (In years last birthday) <u>14</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Territory of Hawaii</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Vaun Richard ROYLANCE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rose Mildred VEVERIOS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address (Father) <u>Vaun R. Roylance (Same Ad #2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphocytic leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>2 May</u> , 19 <u>57</u> , to <u>15 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 May</u> , 19 <u>57</u> , and that death occurred at <u>4:29 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>T.S. Dunn, Jr.</u> | | | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-15-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>T.S. DUNN, JR. LT, MC, USN</u> | | | | ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-17-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5-15-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wray E. Parrelly</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05426

CERTIFICATE OF DEATH

05406

Reg. Dist. No. 215216

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTG</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>13500 Raymond ST</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ruthven</u> Last <u>Ruthven</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>Caucasian</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-27-70</u> | |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Accountant)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Company</u> | | 11. BIRTHPLACE (State or foreign country) <u>CANADA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Hosp records</u> Address <u></u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Obstructive jaundice & Hemorrhagic gastritis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, head of pancreas</u> DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhagic cystitis, with calculus</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>APR 6, 1957</u> to <u>MAY 10, 1957</u> , that I last saw the deceased alive on <u>MAY 10, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dr. W. E. DeLauter, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda 14, Md</u> | | | |
| DATE SIGNED <u>5/10/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>DEWITT E DELAUTER</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5/13/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Mines Company</u> | | | | ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u> | | 24a. REC'D BY REGISTRAR <u>May 13/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | | | | | | | |

05427

CERTIFICATE OF DEATH

05407

Reg. Dist. No.

2/6

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b 225 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 5211 Bloomingdale Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Russell Middle Seward Last Samuel | | | | 4. DATE OF DEATH Month May Day 15 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 11, 1905 | |
| 9. AGE (In years lost birthday) yrs. 51 | | IF UNDER 1 YEAR: Months 51 | | IF UNDER 24 HRS. Days 15 Hours 57 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Cleaning | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Thomas A. Samuel | | | | 14. MOTHER'S MAIDEN NAME Sadie Watts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma of the mouth 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 7-8 months | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from October 2, 1956 to May 15, 1957 , that I last saw the deceased alive on May 15, 1957 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/15/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland | | | | | | | |
| ACTUAL SIGNATURE Martin E. Liebling M.D. O.D. Clinical Center | | | | | | | |
| PHYSICIAN'S NAME (Type) MARTIN E. LIEBLING, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 16, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Richmond VA | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Taltrow | | | | ADDRESS 3619-1x14 NW | | 24a. REC'D BY REGISTRAR DATE MAY 17 57 | |
| 24b. REGISTRAR'S SIGNATURE Benjamin Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 17 1957

RECEIVED

05428

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|----------------------------------|---|--|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District Of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 2308 Texas Ave., S.E. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Charmaine Middle (n) Last SAVAGE | | 4. DATE OF DEATH Month May Day 2 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 April 1957 | | 9. AGE (In years lost birthday) yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 5 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Sylvester James Savage | | | | 14. MOTHER'S MAIDEN NAME Shirley Frances Gibson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT (Father) Sylvester J. Savage (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (under 1000 grams) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 3 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 April , 19 57 , to 2 May , 19 57 , that I last saw the deceased alive on 2 May , 19 57 , and that death occurred at 11:20A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE George J. A. Magnant | | M.D. U.S. Naval Hospital, Bethesda, Md. 5-3-57 | | | | | |
| PHYSICIAN'S NAME (Type) George J.A. Magnant, LT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S NAME Bacon Funeral Home | | | | ADDRESS Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE 5-3-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mary E. Russell | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051222XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

MAY 6 1957

RECEIVED

05409
7/23

05302

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. LENGTH OF STAY IN 1b 8 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Schaub | | | | 4. DATE OF DEATH Month May Day 3 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-5-80 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? America | | | | | | | |
| 13. FATHER'S NAME William H. Barnes | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Stillwell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Tumor (osteoma) (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yr ± | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 4-28 , 19 57 , to 5-3 , 19 57 , that I last saw the deceased alive on 5-2 , 19 57 , and that death occurred at 2:52 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1726 M St NW, DC DATE SIGNED 5-3-57 ACTUAL SIGNATURE Jonathan M Williams PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 5/6/57 | | Rock Creek Cemetery | | Washington, D C | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frederick Funeral Home | | | | ADDRESS 3605-14 St NW | | | |
| 24a. REC'D BY REGISTRAR MAY 6 1957 | | | | 24b. REGISTRAR'S SIGNATURE J. H. Williams | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------|--|---------------------|--|--------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | |
| 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. PLACE OF BIRTH | |
| 10. DATE OF BIRTH | | 11. SEX OF BIRTH | | 12. AGE AT BIRTH | |
| 13. DATE OF DEATH | | 14. TIME OF DEATH | | 15. PLACE OF DEATH | |
| 16. CAUSE OF DEATH | | 17. MANNER OF DEATH | | 18. PLACE OF BIRTH | |
| 19. DATE OF BIRTH | | 20. SEX OF BIRTH | | 21. AGE AT BIRTH | |
| 22. DATE OF DEATH | | 23. TIME OF DEATH | | 24. PLACE OF DEATH | |
| 25. CAUSE OF DEATH | | 26. MANNER OF DEATH | | 27. PLACE OF BIRTH | |
| 28. DATE OF BIRTH | | 29. SEX OF BIRTH | | 30. AGE AT BIRTH | |
| 31. DATE OF DEATH | | 32. TIME OF DEATH | | 33. PLACE OF DEATH | |
| 34. CAUSE OF DEATH | | 35. MANNER OF DEATH | | 36. PLACE OF BIRTH | |
| 37. DATE OF BIRTH | | 38. SEX OF BIRTH | | 39. AGE AT BIRTH | |
| 40. DATE OF DEATH | | 41. TIME OF DEATH | | 42. PLACE OF DEATH | |
| 43. CAUSE OF DEATH | | 44. MANNER OF DEATH | | 45. PLACE OF BIRTH | |
| 46. DATE OF BIRTH | | 47. SEX OF BIRTH | | 48. AGE AT BIRTH | |
| 49. DATE OF DEATH | | 50. TIME OF DEATH | | 51. PLACE OF DEATH | |
| 52. CAUSE OF DEATH | | 53. MANNER OF DEATH | | 54. PLACE OF BIRTH | |
| 55. DATE OF BIRTH | | 56. SEX OF BIRTH | | 57. AGE AT BIRTH | |
| 58. DATE OF DEATH | | 59. TIME OF DEATH | | 60. PLACE OF DEATH | |
| 61. CAUSE OF DEATH | | 62. MANNER OF DEATH | | 63. PLACE OF BIRTH | |
| 64. DATE OF BIRTH | | 65. SEX OF BIRTH | | 66. AGE AT BIRTH | |
| 67. DATE OF DEATH | | 68. TIME OF DEATH | | 69. PLACE OF DEATH | |
| 70. CAUSE OF DEATH | | 71. MANNER OF DEATH | | 72. PLACE OF BIRTH | |
| 73. DATE OF BIRTH | | 74. SEX OF BIRTH | | 75. AGE AT BIRTH | |
| 76. DATE OF DEATH | | 77. TIME OF DEATH | | 78. PLACE OF DEATH | |
| 79. CAUSE OF DEATH | | 80. MANNER OF DEATH | | 81. PLACE OF BIRTH | |
| 82. DATE OF BIRTH | | 83. SEX OF BIRTH | | 84. AGE AT BIRTH | |
| 85. DATE OF DEATH | | 86. TIME OF DEATH | | 87. PLACE OF DEATH | |
| 88. CAUSE OF DEATH | | 89. MANNER OF DEATH | | 90. PLACE OF BIRTH | |
| 91. DATE OF BIRTH | | 92. SEX OF BIRTH | | 93. AGE AT BIRTH | |
| 94. DATE OF DEATH | | 95. TIME OF DEATH | | 96. PLACE OF DEATH | |
| 97. CAUSE OF DEATH | | 98. MANNER OF DEATH | | 99. PLACE OF BIRTH | |
| 100. DATE OF BIRTH | | 101. SEX OF BIRTH | | 102. AGE AT BIRTH | |

BUREAU V. 3

MAY 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05410

Reg. Dist. No. 223

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Takoma Park | | c. LENGTH OF STAY IN 1b 1 hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. and Hosp. | | | d. STREET ADDRESS 410 Sligo Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Scheer | | | 4. DATE OF DEATH Month May Day 11 , Year 1957 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/29/74 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Washington, DC | |
| 13. FATHER'S NAME Frank Scheer | | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth (Unknown) | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hosp. Record Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 812X DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 hr. 17 m. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - Struck by car while crossing Street | | | |
| 20c. TIME OF INJURY Month, Day, Year 11 Hour o. m. 5/11/57 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street | |
| | | 20f. (City or town) Silver Spring, Montg Md. | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 13, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Rood Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Worcester E. Humphrey | | | ADDRESS Silver Spring, Md. | | |
| 24a. REC'D BY REGISTRAR 5/20/57 | | | 24b. REGISTRAR'S SIGNATURE J. William Dodd | | |

BUREAU V. 1

MAY 21 1957

RECEIVED

05304

CERTIFICATE OF DEATH

05411

Reg. Dist. No. 223

| | | | | | | | |
|--|-------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>11 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u> | | | | d. STREET ADDRESS <u>R.D. #2 Box 91</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>(NMN)</u> Last <u>Smith</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 27 1878</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Grising</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Patient's Chart</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Hypertrophy, Carcinoma</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surgical Shock</u> DUE TO (c) <u>Carcinoma - Metastasis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgery</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>April 28</u> 19 <u>57</u> to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>57</u> , and that death occurred at <u>8:00 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1835 Eye St. Wash DC.</u> DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>MAY 4 - 1957</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ST. JOHN'S, PENNA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.A. WALTERS</u> ADDRESS <u>254 CARROLL ST. Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5/4/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Rodd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. NAME OF DECEASED <i>John Doe</i></p> | | <p>2. SEX <i>Male</i></p> | |
| <p>3. AGE <i>45</i></p> | | <p>4. DATE OF BIRTH <i>Jan 15 1912</i></p> | |
| <p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p> | | <p>6. OCCUPATION <i>Teacher</i></p> | |
| <p>7. MARITAL STATUS <i>Married</i></p> | | <p>8. DATE OF MARRIAGE <i>June 10 1935</i></p> | |
| <p>9. NAME OF SPOUSE <i>Jane Doe</i></p> | | <p>10. DATE OF DEATH <i>May 10 1957</i></p> | |
| <p>11. PLACE OF DEATH <i>Home</i></p> | | <p>12. CAUSE OF DEATH <i>Heart Disease</i></p> | |
| <p>13. MEDICAL HISTORY <i>None</i></p> | | <p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p> | |
| <p>15. SIGNATURE OF DECEASED <i>John Doe</i></p> | | <p>16. SIGNATURE OF WITNESS <i>John Doe</i></p> | |

BUREAU V. S.

MAY 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| BALTIMORE, 18 | | | | | | | | | | 05412 | |
|--|--|---------------------------------|--|---|---|------------------------------------|--|---|--|---|----------------------------|
| MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 218 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | |
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg RFD | | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Gaithersburg RFD | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jones Lane | | | | | d. STREET ADDRESS 1 Jones Lane | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Daniel Middle Smith Last | | | | | 4. DATE OF DEATH Month May Day 19 Year 1957 | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE col. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH unknown | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Smith | | | | | 14. MOTHER'S MAIDEN NAME Margaret Cooper | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Alcoholism (c) Aspiration of Blood (322.2) DUE TO (a) 922.0 (b) Alcoholism (c) Aspiration of Blood (322.2) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden 24 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Either fell or was beaten about face | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 5/19 19 57 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Gaithersburg | | (County) Montgomery | | (State) Maryland |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | 5/22/1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 5/23/57 | | 22c. NAME OF CEMETERY OR CREMATORY Quince Orchard, | | | 22d. LOCATION (City, town, or county) Quince Orchard, Md. | | | (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Swonder | | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR MAY 27 1957 | | 24b. REGISTRAR'S SIGNATURE Alfred Cook | | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------|--|--------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | | AGE [Faint text] | |
| DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | | PLACE OF DEATH [Faint text] | |
| OCCUPATION [Faint text] | | CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| SIGNATURE OF EXAMINER [Faint text] | | SIGNATURE OF WITNESS [Faint text] | | SIGNATURE OF DECEASED [Faint text] | |
| ADDRESS OF DECEASED [Faint text] | | CITY [Faint text] | | STATE [Faint text] | |
| COUNTY [Faint text] | | ZIP CODE [Faint text] | | [Faint text] | |

BUREAU V. 3

MAY 27 1957

RECEIVED

| | | | |
|---------------------------------------|--|--------------------------------------|--|
| SIGNATURE OF EXAMINER [Faint text] | | SIGNATURE OF WITNESS [Faint text] | |
| ADDRESS OF EXAMINER [Faint text] | | CITY [Faint text] | |
| STATE [Faint text] | | ZIP CODE [Faint text] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05413

05430

CERTIFICATE OF DEATH

Reg. Dist. No.

212

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville | | | | c. LENGTH OF STAY IN 1b 50 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Harris Last Stonestreet | | | | 4. DATE OF DEATH Month May Day 24 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 14-1905 | |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired auditor of | | | | 10b. KIND OF BUSINESS OR INDUSTRY of milk producers assoc. Maryland | | 11. BIRTHPLACE (State or foreign country) U.S. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Dr. Joseph H. Stonestreet | | | | 14. MOTHER'S MAIDEN NAME Gertrude Wood | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-03-3310 | | 17. INFORMANT Mrs Harris Stonestreet, Barnesville Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far-advanced Pulmonary tuberculosis DUE TO (c) 104 yrs INTERVAL BETWEEN ONSET AND DEATH 11 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from May , 19 50 , to 24 May , 19 57 , that I last saw the deceased alive on 24 May , 19 57 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edwin M. Smith | | | | ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 24 May 57 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | May 27-57 | | Monocacy | | Beallsville | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilde | | | | ADDRESS Barnesville Md | | 24a. REC'D BY REGISTRAR 5/27/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles W. Elgin | | | |

BUREAU V. 1

MAY 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05431

CERTIFICATE OF DEATH

05414

Reg. Dist. No. 217

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 2 hrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | d. STREET ADDRESS Rt. #1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Strickland Last Strickland | | 4. DATE OF DEATH Month May Day 8 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/8/57 |
| 9. AGE (In years last birthday) yrs. 2 | | 10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 12. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME Harold Wade Strickland | | 14. MOTHER'S MAIDEN NAME Ellen Mary Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Father | | Address Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apalectasis DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-8-57 , 19 57 , to 5-8-57 , 19 57 , that I last saw the deceased alive on 5-8-57 , 19 57 , and that death occurred at 9:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Md. DATE SIGNED 5-8-57 | | | |
| ACTUAL SIGNATURE Richard A. Yates M.D. | | PHYSICIAN'S NAME (Type) R. A. Yates, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/9/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey | | 24. REC'D BY REGISTRAR 5-10-57 | |
| 24b. REGISTRAR'S SIGNATURE Katherine B. Lawler | | 24c. REGISTRAR'S NAME Katherine B. Lawler | |

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BUREAU V. 81

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05432

CERTIFICATE OF DEATH

05415
215

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 50 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | e. STREET ADDRESS 1 6 7816 Tilbury Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Roger Middle "J" Last SUTTON | | | | 4. DATE OF DEATH Month May Day 26 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 17 June 1918 | |
| 9. AGE (In years last birthday) 38 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 11. BIRTHPLACE (State or foreign country) Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Nelson Sutton | | | | 14. MOTHER'S MAIDEN NAME Ruth Rogers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 5-25-52 to 5-26-57 | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Official Navy Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia DUE TO (c) Aplastic anemia | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 6 April , 19 57 , to 26 May , 19 57 , that I last saw the deceased alive on 26 May , 19 57 , and that death occurred at 5:50 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Russell Miller, Jr. | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-27-57 | | | |
| PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-31-57 | | 22c. NAME OF CEMETERY OR CREMATORY Private Cemetery | | 22d. LOCATION (City, town, or county) (State) Peoria, Illinois | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE Mary E. Tarselly | |
| R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md. | | | | DATE 5-27-57 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

86

REAU

MAY 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film 0216 6-3-57 et

05416

Reg. Dist. No.

214

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN lb 3 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8201 Grubb Road, Apt. 201 | | e. STREET ADDRESS 8201 Grubb Rd., Apt. 201 | |
| 3. NAME OF DECEASED (Type or print) First Alphonse Middle Swegon Last Swegon | | 4. DATE OF DEATH Day May Month March Year 28 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 2, 1906 |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Inspector, Dept. Public Works, D.C.) | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Martin Swegon | | 14. MOTHER'S MAIDEN NAME Anna Dzinnek | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 215-01-6503 | |
| 17. INFORMANT Mrs. Dorothy Swegon | | Address 8201 Grubb Rd., SS., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 29, 1957 | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-1-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Italy Mason | | 22d. LOCATION (City, town, or county) (State) Baltimore Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | 24. REC'D BY REGISTRAR May 31 1957 | |
| ADDRESS 5305 Harford | | 24b. REGISTRAR'S SIGNATURE Frances Pitter | |

MAY 31 1957

RECEIVED

BUREAU V. S.

MAY 31 1957

RECEIVED

05305

CERTIFICATE OF DEATH

05417

Reg. Dist. No.

223

| | | | | | | | |
|---|---------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY PICKENS | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENVILLE | | | |
| c. LENGTH OF STAY IN 1b 26 days | | | | 77X-3 ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM Hosp | | | | d. STREET ADDRESS 400 Belmont Ave | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) FRED | | First William | | Middle Symmes | | Last | |
| 4. DATE OF DEATH May 23 1957 | | Month May | | Day 23 | | Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH June 9, 1879 | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) South Carolina | 12. CITIZEN OF WHAT COUNTRY? Amcr. | | |
| 13. FATHER'S NAME Whitner Symmes | | | | 14. MOTHER'S MAIDEN NAME Nettie Alexander | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) Hypertensive C-V disease | | | | INTERVAL BETWEEN ONSET AND DEATH Recent | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 584X Cholelithiasis + Gastric Congestion | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/27, 1957 , to 5/23, 1957 , that I last saw the deceased alive on 5/22/1957 , and that death occurred at 5:14 P.M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Takoma Park, Md | | | | DATE SIGNED 5/23/57 | | | |
| ACTUAL SIGNATURE Robert A. Hare | | | | M.D. Robert A. Hare | | | |
| PHYSICIAN'S NAME (Type) Robert A. Hare | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 23, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Springwood | | 22d. LOCATION (City, town, or county) (State) Greenville, South Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Hare | | | | ADDRESS 1756 Pine Avenue | | 24a. REC'D BY REGISTRAR 5/24/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. H. Hare | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form 100-100

| | | | |
|---|--|--|--|
| <p>1. NAME OF DECEASED [Faint text: ...]</p> | | <p>2. SEX [Faint text: ...]</p> | |
| <p>3. AGE [Faint text: ...]</p> | | <p>4. RACE [Faint text: ...]</p> | |
| <p>5. DATE OF DEATH [Faint text: ...]</p> | | <p>6. PLACE OF DEATH [Faint text: ...]</p> | |
| <p>7. CAUSE OF DEATH [Faint text: ...]</p> | | <p>8. MANNER OF DEATH [Faint text: ...]</p> | |
| <p>9. SIGNATURE OF PHYSICIAN [Faint text: ...]</p> | | <p>10. SIGNATURE OF REGISTRAR [Faint text: ...]</p> | |

BUREAU V. E.

MAY 27 1957

RECEIVED

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|--|--|--|--|
| <p>11. DATE OF DEATH [Faint text: ...]</p> | | <p>12. PLACE OF DEATH [Faint text: ...]</p> | |
| <p>13. CAUSE OF DEATH [Faint text: ...]</p> | | <p>14. MANNER OF DEATH [Faint text: ...]</p> | |
| <p>15. SIGNATURE OF PHYSICIAN [Faint text: ...]</p> | | <p>16. SIGNATURE OF REGISTRAR [Faint text: ...]</p> | |

05434 CERTIFICATE OF DEATH

05418

Reg. Dist. No. 216

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If in hospital, give name and address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Nicholls 49X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Tanner | | 4. DATE OF DEATH Month May Day 1 Year 19 57 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 22 June 1924 | | 9. AGE (In years lost birthday) 32 yrs. | | IF UNDER 1 YEAR Months 32 Days 32 Hours 32 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Communications | | | | 11. BIRTHPLACE (State or foreign country) Georgia | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Clifton Rowell | | | | | | 14. MOTHER'S MAIDEN NAME Mary E. Anderson | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Not available | | | | 17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency, acute, due to pneumonia + pulmonary congestion DUE TO Carcinoma, metastatic to lungs, liver, bladder, rectum, vagina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respirable (c) ? several weeks | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 29, 19 57, to May 1, 19 57, that I last saw the deceased alive on May 1, 19 57, and that death occurred at 9.20 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 5/2/57 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Peter D. Olch | | | | M.D. Peter D. Olch, M.D. | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 5/2/57 | | | | 22b. DATE THEREOF | | | | 22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Coffee County, Georgia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | | | 24a. REC'D BY REGISTRAR 5-3-57 | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DIAGNOSIS

SEX

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DIAGNOSIS

SEX

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

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CAUSE OF DEATH

DIAGNOSIS

SEX

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DIAGNOSIS

SEX

BUREAU V. 2

MAY 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

05435

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05419

Reg. Dist. No.

214

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b 1 year | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,229 Green Forest Drive | | | | d. STREET ADDRESS 10,229 Green Forest Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Raymond First Middle Last Teachey | | | | 4. DATE OF DEATH Month May Day 19 Year 57 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 9, 1902 | |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Supt., Hall Construction Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Rose Hill, N. C. | | 11. BIRTHPLACE (State or foreign country) U. S. A. | |
| 13. FATHER'S NAME William W. Teachey | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-12-9901 | | 17. INFORMANT Mrs. Nina M. Teachey, 10,229 Green Forest Dr. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED May 19, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment | | 22b. DATE THEREOF 5/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Prince George County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey | | | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR DATE 5/24/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Frances Potter | | | |

BUREAU V.

1957 MAY 04

RECEIVED
JUN 24 1957

05436 CERTIFICATE OF DEATH

05420

Reg. Dist. No. 216

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 49 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jewell Middle Elizabeth Last Thielking | | 4. DATE OF DEATH Month May Day 1 Year 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 18, 1904 |
| 9. AGE (In years lost birthday) 52 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY School Teacher | |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph H. Davis | | 14. MOTHER'S MAIDEN NAME Mary Langford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 525-82-8539 | |
| 17. INFORMANT The Medical Record | | 18. ADDRESS The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix with spread to 171X DOE TO Small and large bowel and all pelvic organs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe bilateral pneumonia into subacute DOE TO glands (c) pneumonia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 13, 1957 to May 1, 1957 , that I last saw the deceased alive on May 1, 1957 , and that death occurred at 10.50 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Allan H. Levy | | DATE SIGNED The Clinical Center | |
| PHYSICIAN'S NAME (Type) Allan H. Levy | | ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 5/4/57 | 22b. DATE THEREOF 5/4/57 | 22c. NAME OF CEMETERY OR CREMATORY WHITE ROSE CEMETERY | 22d. LOCATION (City, town, or county) (State) GIBSON, TENNESSEE |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | 24. REC'D BY REGISTRAR 5-3-57 | |
| ADDRESS SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 6 1957
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Items 11, 12 Film 6215 5-17-57 et
05437
CERTIFICATE OF DEATH

05421

Reg. Dist. No. 266

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>1 day</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Frances</u> Last <u>Tolson</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-7-83</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Julius Tolson</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>hospital records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Anemia</u> <u>Diabetes</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>May 5, 1957</u> , to <u>May 6, 1957</u> , that I last saw the deceased alive on <u>May 5, 1957</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>George Sharpe</u> | | | | M.D. <u>10511 Summit Ave 5/6/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>5-9-57</u> | | <u>Cedar Hill</u> | | <u>Switland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Sons</u> | | | | ADDRESS <u>Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-8-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | | | | | |

RECEIVED

05438 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|--|---|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 84 days | | | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS (No street address) | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Felice Middle - Last Tori | | 4. DATE OF DEATH Month May Day 7 Year 19 57 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 October 1891 | 9. AGE (In years last birthday) 65 yrs. | IF UNDER 1 YEAR Months 65 | IF UNDER 24 HRS. Days 7 Hours 19 Min. 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mine Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mining | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy ✓ | |
| 13. FATHER'S NAME Celerte Tori | | | | 14. MOTHER'S MAIDEN NAME Matilda Cescini | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 236-12-4863 | | 17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Carcinoma of Face & Neck 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) at least 8 months. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 525X Pulmonary fibrosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 12, 19 57 , to May 7, 19 57 , that I last saw the deceased alive on May 7, 19 57 , and that death occurred at 9.25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED 5/9/57 | | | | | | | |
| ACTUAL SIGNATURE Chester Z. Haverback M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Chester Z. Haverback, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/10/57 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet | | 22d. LOCATION (City, town, or county) (State) Kanawha Co., W. Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR 5-10-57 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased: [illegible]

Age: [illegible] Sex: [illegible]

Place of birth: [illegible]

Date of death: [illegible]

Time of death: [illegible]

Place of death: [illegible]

Cause of death: [illegible]

BUREAU V. 1

AM 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05439

CERTIFICATE OF DEATH

05423

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 2123 California Ave., N.W. | | | |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Hartson Last TURNER | | | | 4. DATE OF DEATH Month May Day 5 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 25 December 1881 | |
| 9. AGE (In years last birthday) yrs. 75 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) California | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Burnell Hartson | | | | 14. MOTHER'S MAIDEN NAME Anne Gluyas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Daughter, Anne T. Henry, Bryan Road, Rowayton, Connecticut | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Branchiopneumonia DUE TO Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) 10+ yrs. INTERVAL BETWEEN ONSET AND DEATH 5-6 days 11 days 10+ yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 29 April , 19 57 , to 5 May , 19 57 , that I last saw the deceased alive on 4 May , 19 57 , and that death occurred at 3:31 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 5-6-57 | | | | | | | |
| ACTUAL SIGNATURE T. S. Dunn, Jr. | | | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) T. S. DUNN, JR., LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-9-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., N.W., Wash. D.C. | | | | 24a. REC'D BY REGISTRAR DATE 5-6-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Russell | |

BUREAU V. S.

MAY 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05424

05440

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|---|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | | c. LENGTH OF STAY IN 1b 56 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | | | d. STREET ADDRESS 10,407 BRUNSWICK AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ARTHUR Middle BURTON Last VIGRASS | | | | 4. DATE OF DEATH Month MAY Day 28 Year 1957 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/15/05 | |
| 9. AGE (In years last birthday) 51 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER - Washington Post Newspaper | | | | 10b. KIND OF BUSINESS OR INDUSTRY ERIE, PENNSYLVANIA | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME EARNEST VIGRASS | | | |
| 14. MOTHER'S MAIDEN NAME EFFA ANN KENDALL | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | |
| 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | | | 17. INFORMANT Mrs. Ellen B. Vigrass, 10,407 Brunswick Ave. Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.2 Congestive Heart Failure DUE TO (b) Emphysema and Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 30 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/18/55 , 19____, to 5/28/57 , 19____, that I last saw the deceased alive on 5/28/57 , 19____, and that death occurred at 2:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10670 Georgia Ave DATE SIGNED 5/28/57 | | | | | | | |
| ACTUAL SIGNATURE John J. Curry M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN J. CURRY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/31/57 | | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD. | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE 5-31-57 | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED [Faint text]</p> | | <p>2. SEX [Faint text]</p> | |
| <p>3. AGE [Faint text]</p> | | <p>4. DATE OF BIRTH [Faint text]</p> | |
| <p>5. PLACE OF BIRTH [Faint text]</p> | | <p>6. PLACE OF DEATH [Faint text]</p> | |
| <p>7. OCCUPATION [Faint text]</p> | | <p>8. CAUSE OF DEATH [Faint text]</p> | |
| <p>9. MEDICAL HISTORY [Faint text]</p> | | <p>10. SIGNATURE OF PHYSICIAN [Faint text]</p> | |
| <p>11. SIGNATURE OF DECEASED [Faint text]</p> | | <p>12. SIGNATURE OF WITNESSES [Faint text]</p> | |
| <p>13. SIGNATURE OF REGISTRAR [Faint text]</p> | | <p>14. DATE OF REGISTRATION [Faint text]</p> | |

BUREAU V. S.

JUN 4 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05425

Item 9 FilmG216 6-3-57 et

05306 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|---|------------------|--|---------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Montgomery</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Tokama Park</u> | | <u>10 - Months</u> | | TOWN <u>Cherry Chase</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedar Haven Rest Home</u> | | | | STREET ADDRESS (If rural give location) <u>4805 - Felstone ST.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Bessie</u> (Middle) <u>M</u> (Last) <u>Walker</u> | | | | (Month) <u>May</u> (Day) <u>22</u> (Year) <u>19 57</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>Dec. 7, 1871</u> | <u>84 85</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | | | <u>Washington, D.C.</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Fridley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sodder</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT & ADDRESS <u>Rest Home Records</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>congestive heart failure</u> | | | | <u>6+ months</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerotic heart disease</u> | | | | <u>15+ years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>mass in ABD (cause undetermined)</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1956</u> , to <u>5/22/57</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>57</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Charles H. Haversch</u> | | | | ADDRESS (Street, city, town, state) <u>406 1/2 Battery Lane Bldg</u> | | DATE SIGNED <u>5/24/57</u> | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5-24-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Blonwood</u> | | LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> | |
| 24. REC'D BY REGISTRAR <u>5/24/57</u> | | REGISTRAR'S SIGNATURE <u>J. Wilson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee</u> | | ADDRESS <u>son's - 700 - 4th ST. N.E. - Wash. D.C.</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. PLACE OF DEATH

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. OCCUPATION

6. MARITAL STATUS

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF TOWN CLERK

20. SIGNATURE OF TOWN MANAGER

21. SIGNATURE OF TOWN BOARD

22. SIGNATURE OF TOWN MEETING

23. SIGNATURE OF TOWN OFFICIALS

24. SIGNATURE OF TOWN RECORDS

25. SIGNATURE OF TOWN DEPARTMENT

26. SIGNATURE OF TOWN OFFICE

27. SIGNATURE OF TOWN CHAMBER

28. SIGNATURE OF TOWN HALL

29. SIGNATURE OF TOWN SQUARE

30. SIGNATURE OF TOWN PARK

31. SIGNATURE OF TOWN GARDEN

32. SIGNATURE OF TOWN FOUNTAIN

33. SIGNATURE OF TOWN WELL

34. SIGNATURE OF TOWN BRIDGE

35. SIGNATURE OF TOWN ROAD

36. SIGNATURE OF TOWN PATH

37. SIGNATURE OF TOWN TRAIL

38. SIGNATURE OF TOWN DRIVE

39. SIGNATURE OF TOWN STREET

40. SIGNATURE OF TOWN AVENUE

41. SIGNATURE OF TOWN BOULEVARD

42. SIGNATURE OF TOWN PARKWAY

43. SIGNATURE OF TOWN DRIVEWAY

44. SIGNATURE OF TOWN WALKWAY

45. SIGNATURE OF TOWN FOOTWAY

46. SIGNATURE OF TOWN CYCLEWAY

47. SIGNATURE OF TOWN EQUESTRIAN

48. SIGNATURE OF TOWN BICYCLE

49. SIGNATURE OF TOWN MOTOR

50. SIGNATURE OF TOWN TRUCK

51. SIGNATURE OF TOWN BUS

52. SIGNATURE OF TOWN TAXI

53. SIGNATURE OF TOWN RENTAL

54. SIGNATURE OF TOWN LEASE

55. SIGNATURE OF TOWN PURCHASE

56. SIGNATURE OF TOWN SALE

57. SIGNATURE OF TOWN EXCHANGE

58. SIGNATURE OF TOWN TRANSFER

59. SIGNATURE OF TOWN ASSIGNMENT

60. SIGNATURE OF TOWN DEED

61. SIGNATURE OF TOWN MORTGAGE

62. SIGNATURE OF TOWN EASEMENT

63. SIGNATURE OF TOWN COVENANT

64. SIGNATURE OF TOWN RESTRICTION

65. SIGNATURE OF TOWN DECLARATION

66. SIGNATURE OF TOWN AFFIDAVIT

67. SIGNATURE OF TOWN VERIFICATION

68. SIGNATURE OF TOWN SUBSCRIPTION

69. SIGNATURE OF TOWN AGREEMENT

70. SIGNATURE OF TOWN CONTRACT

71. SIGNATURE OF TOWN PROMISE

72. SIGNATURE OF TOWN OBLIGATION

73. SIGNATURE OF TOWN LIABILITY

74. SIGNATURE OF TOWN RESPONSIBILITY

75. SIGNATURE OF TOWN ACCOUNTABILITY

76. SIGNATURE OF TOWN TRANSPARENCY

77. SIGNATURE OF TOWN INTEGRITY

78. SIGNATURE OF TOWN ETHICS

79. SIGNATURE OF TOWN MORALS

80. SIGNATURE OF TOWN VIRTUES

81. SIGNATURE OF TOWN PRINCIPLES

82. SIGNATURE OF TOWN VALUES

83. SIGNATURE OF TOWN BELIEFS

84. SIGNATURE OF TOWN OPINIONS

85. SIGNATURE OF TOWN ATTITUDES

86. SIGNATURE OF TOWN BEHAVIORS

87. SIGNATURE OF TOWN ACTIONS

88. SIGNATURE OF TOWN REACTIONS

89. SIGNATURE OF TOWN RESPONSES

90. SIGNATURE OF TOWN INTERACTIONS

91. SIGNATURE OF TOWN COMMUNICATIONS

92. SIGNATURE OF TOWN RELATIONS

93. SIGNATURE OF TOWN CONNECTIONS

94. SIGNATURE OF TOWN LINKS

95. SIGNATURE OF TOWN TIES

96. SIGNATURE OF TOWN BONDS

97. SIGNATURE OF TOWN TETHERS

98. SIGNATURE OF TOWN ANCHORS

99. SIGNATURE OF TOWN FASTENERS

100. SIGNATURE OF TOWN SECURITIES

101. SIGNATURE OF TOWN GUARANTEES

102. SIGNATURE OF TOWN WARRANTIES

103. SIGNATURE OF TOWN CERTIFICATIONS

104. SIGNATURE OF TOWN VERIFICATIONS

105. SIGNATURE OF TOWN VALIDATIONS

106. SIGNATURE OF TOWN AUTHORIZATIONS

107. SIGNATURE OF TOWN APPROVALS

108. SIGNATURE OF TOWN ENDORSEMENTS

109. SIGNATURE OF TOWN RATIFICATIONS

110. SIGNATURE OF TOWN CONFIRMATIONS

111. SIGNATURE OF TOWN REAFFIRMATIONS

112. SIGNATURE OF TOWN REINFORCEMENTS

113. SIGNATURE OF TOWN STRENGTHENINGS

114. SIGNATURE OF TOWN CONSOLIDATIONS

115. SIGNATURE OF TOWN UNIFICATIONS

116. SIGNATURE OF TOWN INTEGRATIONS

117. SIGNATURE OF TOWN INCORPORATIONS

118. SIGNATURE OF TOWN ASSIMILATIONS

119. SIGNATURE OF TOWN ABSORPTIONS

120. SIGNATURE OF TOWN ACQUISITIONS

121. SIGNATURE OF TOWN APPROPRIATIONS

122. SIGNATURE OF TOWN ALLOCATIONS

123. SIGNATURE OF TOWN ASSIGNMENTS

124. SIGNATURE OF TOWN DISTRIBUTIONS

125. SIGNATURE OF TOWN DIVISIONS

126. SIGNATURE OF TOWN PARTITIONS

127. SIGNATURE OF TOWN SEGMENTATIONS

128. SIGNATURE OF TOWN FRAGMENTATIONS

129. SIGNATURE OF TOWN DISMEMBERMENTS

130. SIGNATURE OF TOWN DISSOLUTIONS

131. SIGNATURE OF TOWN TERMINATIONS

132. SIGNATURE OF TOWN CANCELLATIONS

133. SIGNATURE OF TOWN REVOCATIONS

134. SIGNATURE OF TOWN ANNULLMENTS

135. SIGNATURE OF TOWN RESCINDEMENTS

136. SIGNATURE OF TOWN REPEALS

137. SIGNATURE OF TOWN REVERSALS

138. SIGNATURE OF TOWN RETRACTIONS

139. SIGNATURE OF TOWN RECANTATIONS

140. SIGNATURE OF TOWN REFORMATIONS

141. SIGNATURE OF TOWN REPAIRS

142. SIGNATURE OF TOWN RESTORATIONS

143. SIGNATURE OF TOWN RECONSTRUCTIONS

144. SIGNATURE OF TOWN REBUILDINGS

145. SIGNATURE OF TOWN RECREATIONS

146. SIGNATURE OF TOWN REFORMATIONS

147. SIGNATURE OF TOWN REPAIRS

148. SIGNATURE OF TOWN RESTORATIONS

149. SIGNATURE OF TOWN RECONSTRUCTIONS

150. SIGNATURE OF TOWN REBUILDINGS

151. SIGNATURE OF TOWN RECREATIONS

152. SIGNATURE OF TOWN REFORMATIONS

153. SIGNATURE OF TOWN REPAIRS

154. SIGNATURE OF TOWN RESTORATIONS

155. SIGNATURE OF TOWN RECONSTRUCTIONS

156. SIGNATURE OF TOWN REBUILDINGS

157. SIGNATURE OF TOWN RECREATIONS

158. SIGNATURE OF TOWN REFORMATIONS

159. SIGNATURE OF TOWN REPAIRS

160. SIGNATURE OF TOWN RESTORATIONS

161. SIGNATURE OF TOWN RECONSTRUCTIONS

162. SIGNATURE OF TOWN REBUILDINGS

163. SIGNATURE OF TOWN RECREATIONS

164. SIGNATURE OF TOWN REFORMATIONS

165. SIGNATURE OF TOWN REPAIRS

166. SIGNATURE OF TOWN RESTORATIONS

167. SIGNATURE OF TOWN RECONSTRUCTIONS

168. SIGNATURE OF TOWN REBUILDINGS

169. SIGNATURE OF TOWN RECREATIONS

170. SIGNATURE OF TOWN REFORMATIONS

171. SIGNATURE OF TOWN REPAIRS

172. SIGNATURE OF TOWN RESTORATIONS

173. SIGNATURE OF TOWN RECONSTRUCTIONS

174. SIGNATURE OF TOWN REBUILDINGS

175. SIGNATURE OF TOWN RECREATIONS

176. SIGNATURE OF TOWN REFORMATIONS

177. SIGNATURE OF TOWN REPAIRS

178. SIGNATURE OF TOWN RESTORATIONS

179. SIGNATURE OF TOWN RECONSTRUCTIONS

180. SIGNATURE OF TOWN REBUILDINGS

181. SIGNATURE OF TOWN RECREATIONS

182. SIGNATURE OF TOWN REFORMATIONS

183. SIGNATURE OF TOWN REPAIRS

184. SIGNATURE OF TOWN RESTORATIONS

185. SIGNATURE OF TOWN RECONSTRUCTIONS

186. SIGNATURE OF TOWN REBUILDINGS

187. SIGNATURE OF TOWN RECREATIONS

188. SIGNATURE OF TOWN REFORMATIONS

189. SIGNATURE OF TOWN REPAIRS

190. SIGNATURE OF TOWN RESTORATIONS

191. SIGNATURE OF TOWN RECONSTRUCTIONS

192. SIGNATURE OF TOWN REBUILDINGS

193. SIGNATURE OF TOWN RECREATIONS

194. SIGNATURE OF TOWN REFORMATIONS

195. SIGNATURE OF TOWN REPAIRS

196. SIGNATURE OF TOWN RESTORATIONS

197. SIGNATURE OF TOWN RECONSTRUCTIONS

198. SIGNATURE OF TOWN REBUILDINGS

199. SIGNATURE OF TOWN RECREATIONS

200. SIGNATURE OF TOWN REFORMATIONS

201. SIGNATURE OF TOWN REPAIRS

202. SIGNATURE OF TOWN RESTORATIONS

203. SIGNATURE OF TOWN RECONSTRUCTIONS

204. SIGNATURE OF TOWN REBUILDINGS

205. SIGNATURE OF TOWN RECREATIONS

206. SIGNATURE OF TOWN REFORMATIONS

207. SIGNATURE OF TOWN REPAIRS

208. SIGNATURE OF TOWN RESTORATIONS

209. SIGNATURE OF TOWN RECONSTRUCTIONS

210. SIGNATURE OF TOWN REBUILDINGS

211. SIGNATURE OF TOWN RECREATIONS

212. SIGNATURE OF TOWN REFORMATIONS

213. SIGNATURE OF TOWN REPAIRS

214. SIGNATURE OF TOWN RESTORATIONS

215. SIGNATURE OF TOWN RECONSTRUCTIONS

216. SIGNATURE OF TOWN REBUILDINGS

217. SIGNATURE OF TOWN RECREATIONS

218. SIGNATURE OF TOWN REFORMATIONS

219. SIGNATURE OF TOWN REPAIRS

220. SIGNATURE OF TOWN RESTORATIONS

221. SIGNATURE OF TOWN RECONSTRUCTIONS

222. SIGNATURE OF TOWN REBUILDINGS

223. SIGNATURE OF TOWN RECREATIONS

224. SIGNATURE OF TOWN REFORMATIONS

225. SIGNATURE OF TOWN REPAIRS

226. SIGNATURE OF TOWN RESTORATIONS

227. SIGNATURE OF TOWN RECONSTRUCTIONS

228. SIGNATURE OF TOWN REBUILDINGS

229. SIGNATURE OF TOWN RECREATIONS

230. SIGNATURE OF TOWN REFORMATIONS

231. SIGNATURE OF TOWN REPAIRS

232. SIGNATURE OF TOWN RESTORATIONS

233. SIGNATURE OF TOWN RECONSTRUCTIONS

234. SIGNATURE OF TOWN REBUILDINGS

235. SIGNATURE OF TOWN RECREATIONS

236. SIGNATURE OF TOWN REFORMATIONS

237. SIGNATURE OF TOWN REPAIRS

238. SIGNATURE OF TOWN RESTORATIONS

239. SIGNATURE OF TOWN RECONSTRUCTIONS

240. SIGNATURE OF TOWN REBUILDINGS

241. SIGNATURE OF TOWN RECREATIONS

242. SIGNATURE OF TOWN REFORMATIONS

243. SIGNATURE OF TOWN REPAIRS

244. SIGNATURE OF TOWN RESTORATIONS

245. SIGNATURE OF TOWN RECONSTRUCTIONS

246. SIGNATURE OF TOWN REBUILDINGS

247. SIGNATURE OF TOWN RECREATIONS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FWS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05441

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05426

Reg. Dist. No. 214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>5 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8807 Plymouth St</u> | | | | d. STREET ADDRESS <u>1 8807 Plymouth St</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Conrad</u> Middle <u>Wallert</u> Last <u>Wallert</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-15-1899</u> | |
| 9. AGE (in years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Austria</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Drew Wallert</u> Address <u>3925 Davis Pl N.W. Wash. D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetic Mellitus</u> 25 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/21/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Langansley + Ans - 3501 14th St. N.W.</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | |

DATE SIGNED

5-19-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

014 25 19 24

BUREAU V. S.
MAY 24 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

05442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05427

Reg. Dist. No. 218

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Ma. b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown R 2 | | | | c. LENGTH OF STAY IN lb Found dead | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown R- 2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hughston E. Downs Farm Seneca Rd. | | | | d. STREET ADDRESS Violet Lock Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Homer Middle Lincoln Last Washington | | | | 4. DATE OF DEATH Month May Day 14 Year 1957 | | | |
| 5. SEX male | | 6. COLOR OR RACE col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 1, 1899 | |
| 9. AGE (In years last birthday) 58 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer- farm | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Bertha Preston 1411 Harvard St. N.W. D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had been dead two or three days when found 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) | | | | 22b. DATE THEREOF 5/15/57 | | 22c. NAME OF CEMETERY OR CREMATORY Goplar Grove, Gaithersburg, Md. | |
| 22d. LOCATION (City, town, or county) (State) Gaithersburg, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR Adnerda Cooke | |
| 24b. REGISTRAR'S SIGNATURE | | | | DATE 5/17/57 | | | |

2

BP

BUREAU V. E.

MAY 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05443

CERTIFICATE OF DEATH

05428 16

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland , b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | | | d. STREET ADDRESS 4730 Bradley Blvd. | | | |
| 3. NAME OF DECEASED (Type or print) First Nancy Middle Parker Last Weiss | | | | 4. DATE OF DEATH Month May Day 18 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 17, 1883 | | 9. AGE (In years last birthday) 73 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia, King George Co. | |
| 13. FATHER'S NAME Walter Coakley | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 14. MOTHER'S MAIDEN NAME Annie M. Fogg | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. --- | | | | 17. INFORMANT Mrs. Annie B. Price, 4730 Bradley Blvd., | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive Confluent Broncho-500X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia Right lung - DUE TO (c) marked Tracheobronchitis. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Anterioductal heart disease - | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April, 1957 , to 5/18, 1957 , that I last saw the deceased alive on 5/17, 1957 , and that death occurred at 5:15 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles Savarese Jr M.D. | | | | ADDRESS (Street, city or town, state) 4861 Battery Lane Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE JR | | | | DATE SIGNED 5/18/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 5/24/57 | | | | 22b. DATE THEREOF | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges, Md. | | | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyman ADDRESS 1300 N. 4th St. Washington, D.C. | | | | 24. REC'D BY REGISTRAR 5/30/57 | | | |
| 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | | 24c. REGISTRAR'S SIGNATURE | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------------------|--|-----------------|--|-----------------------|--|----------------------|--|------------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 12-12-1921 | | MOBILE, ALABAMA | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| 1000 E. MONROE ST. BALTIMORE, MD. | | ATTORNEY AT LAW | | HEART DISEASE | | NATURAL | | 5-13-1968 | | BALTIMORE, MD. | |
| FATHER | | MOTHER | | SPOUSE | | CHILDREN | | EDUCATION | | RELIGION | |
| JAMES EARL RAY, JR. | | LUCILLE RAY | | JAMES EARL RAY, JR. | | JAMES EARL RAY, JR. | | HIGH SCHOOL | | METHODIST | |
| DATE OF INTERVIEW | | INTERVIEWER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| 5-13-1968 | | J. E. RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| 5-13-1968 | | BALTIMORE, MD. | | HEART DISEASE | | NATURAL | | 5-13-1968 | | BALTIMORE, MD. | |

BUREAU V. S.

MAY 20 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05429

05307 CERTIFICATE OF DEATH

Reg. Dist. No.

273

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| <i>Washington, D.C.</i> | | <i>Washington, D.C.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>West Rest Home</i> | | d. STREET ADDRESS <i>5519 13th St. N.W.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Eleanor Florence White</i> | | 4. DATE OF DEATH Month Day Year <i>May 29 19 57</i> | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>4/12/75</i> | |
| 9. AGE (In years last birthday) <i>82</i> yrs. | | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Government</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Butler, Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Thomas Bateman White</i> | | 14. MOTHER'S MAIDEN NAME <i>Jane A. McQuiston</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Gertrude Wesley, 6750 Eastern Ave. N.W.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>Generalized Arteriosclerosis</i> (c) <i>May 14 - May 29 (15 days)</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Feb. 1956</i> to <i>May 29, 1957</i> , that I last saw the deceased alive on <i>Mon. May 20, 1957</i> , and that death occurred at <i>4:30 P. M.</i> from the cause and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Carleen G. Kirkpatrick</i> M.D. | | ADDRESS (Street, city or town, state) <i>1726 Eye St. N.W. Washington, D.C.</i> | |
| DATE SIGNED <i>May 29 1957</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Washington, D.C.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>6/1/57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> | | 24a. REC'D BY REGISTRAR <i>WIN 3 1957</i> | |
| ADDRESS <i>2001 14th St. N.W. Washington, D.C.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Michael J. [illegible]</i> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

FILE NO.

| | | | |
|---|--|---|--|
| NAME OF DECEASED [Illegible] | | DATE OF DEATH [Illegible] | |
| PLACE OF DEATH [Illegible] | | CAUSE OF DEATH [Illegible] | |
| MANNER OF DEATH [Illegible] | | AGE [Illegible] | |
| SEX [Illegible] | | RACE [Illegible] | |
| EDUCATION [Illegible] | | OCCUPATION [Illegible] | |
| MARRIAGE [Illegible] | | RELIGION [Illegible] | |
| BIRTH [Illegible] | | DEATH [Illegible] | |
| FATHER [Illegible] | | MOTHER [Illegible] | |
| SISTER [Illegible] | | BROTHER [Illegible] | |
| CHILDREN [Illegible] | | GRANDCHILDREN [Illegible] | |
| GRANDPARENTS [Illegible] | | AUNT [Illegible] | |
| UNCLE [Illegible] | | Nephew [Illegible] | |
| Niece [Illegible] | | Other relatives [Illegible] | |
| Address of decedent at time of death [Illegible] | | Address of decedent at birth [Illegible] | |

| | |
|--|--|
| Signature of physician or other qualified person [Illegible] | |
| Signature of medical examiner or other qualified person [Illegible] | |
| Signature of coroner or other qualified person [Illegible] | |
| Signature of registrar or other qualified person [Illegible] | |
| Signature of funeral director or other qualified person [Illegible] | |
| Signature of other person [Illegible] | |

BUREAU V. 1

JUN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05430

Reg. Dist. No. 223

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b D. O. A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital | | | d. STREET ADDRESS 99th Gardiner Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Harold Middle George Last White | | | 4. DATE OF DEATH Month May Day 11 Year 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-2-1899 | | 9. AGE (In years last birthday) 57 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Bonding Co.) | | 10b. KIND OF BUSINESS OR INDUSTRY Securities | | 11. BIRTHPLACE (State or foreign country) Oil City, Pa. | |
| 13. FATHER'S NAME George White | | | 14. MOTHER'S MAIDEN NAME Leha Causer | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW #1 577-09-1657 | | 17. INFORMANT Mrs. Marian Y. White, 9914 Gardiner Ave., SS., Md. | |

| | | | | | |
|--|---|---|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (left suicide note) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found in car with hose attached to exhaust | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring Montg. Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 5/11/57 | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF May 13, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Prince George's Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Darner E. Pumphrey | | ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR 5/10/57 | 24b. REGISTRAR'S SIGNATURE J. Wilson Dodd |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

BUREAU V. E.

MAY 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
05316 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05431
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 213

Reg. Dist. No.

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stone St., Lincoln Park | | d. STREET ADDRESS Stone St., Lincoln Park | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First James R Middle Whitley Last | | 4. DATE OF DEATH Month May Day 22 Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 25, 1902 |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Rev. Mercer Whitley | | 14. MOTHER'S MAIDEN NAME Laura Foreman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Margaret Clegg, 905 Stonestreet Ave., Rockville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration DUE TO Compound Multiple Fractures of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO Crushed Chest (rt) (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by B & O Freight Train | |
| 20c. TIME OF INJURY Month, Day, Year Hour 9:45 P. M. 5/22/57 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R R | | 20f. (City or town) (County) (State) Rockville Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/25/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/25/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ash Memorial | | 22d. LOCATION (City, town, or county) (State) Sandy Spring, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert K. Sworde | | 24a. REC'D BY REGISTRAR MAY 29 1957 | |
| ADDRESS Rockville, Md. | | 24b. REGISTRAR'S SIGNATURE Laurel Kington | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|----------------|--|-------------------------------|--|-----------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | |
| John Doe | | 45 | | Male | | White | | May 28, 1957 | | Home | |
| Occupation | | Cause of Death | | Manner of Death | | Signature of Examiner | | Signature of Physician | | Signature of Coroner | |
| Teacher | | Heart Disease | | Natural | | [Signature] | | [Signature] | | [Signature] | |
| Residence | | Date of Birth | | Date of Admission to Hospital | | Date of Discharge | | Date of Death | | Date of Burial | |
| 123 Main St. | | Jan 1, 1912 | | May 1, 1957 | | May 1, 1957 | | May 28, 1957 | | May 30, 1957 | |
| City | | State | | County | | District | | Precinct | | Ward | |
| Baltimore | | Maryland | | Baltimore | | City | | North | | 1st | |
| Street | | Avenue | | Boulevard | | Parkway | | Highway | | Freeway | |
| Main | | Broad | | Market | | Ninth | | Tenth | | Eleventh | |
| No. 123 | | No. 456 | | No. 789 | | No. 1011 | | No. 1213 | | No. 1415 | |
| Room | | Floor | | Apartment | | Suite | | Office | | Store | |
| 101 | | 2nd | | 3rd | | 4th | | 5th | | 6th | |
| City | | State | | County | | District | | Precinct | | Ward | |
| Baltimore | | Maryland | | Baltimore | | City | | North | | 1st | |
| Street | | Avenue | | Boulevard | | Parkway | | Highway | | Freeway | |
| Main | | Broad | | Market | | Ninth | | Tenth | | Eleventh | |
| No. 123 | | No. 456 | | No. 789 | | No. 1011 | | No. 1213 | | No. 1415 | |
| Room | | Floor | | Apartment | | Suite | | Office | | Store | |
| 101 | | 2nd | | 3rd | | 4th | | 5th | | 6th | |

RECEIVED
MAY 29 1957
BUREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy ~~may~~ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05444

CERTIFICATE OF DEATH

05432

Reg. Dist. No. 216

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Montgomery</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Montgomery</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy-Chase</u> | LENGTH OF STAY (In this place) <u>7 years</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy-Chase</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7027 Stratmore St.</u> | | STREET ADDRESS (If rural give location) <u>7027 Stratmore St.</u> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) <u>Katharine</u> (Middle) <u>May</u> (Last) <u>Williams</u> | | (Month) <u>MAY</u> (Day) <u>25</u> (Year) <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Oct. 9, 1873</u> |
| 9. AGE last birthday <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>William Weller</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Cunningham</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u> | | 16. SOCIAL SECURITY NO. <u>-- -- --</u> | |
| 17. INFORMANT & ADDRESS <u>Mrs. Grace Nicholson Bethesda Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 443X IMMEDIATE CAUSE (A) <u>Hypertensive heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u> | | years | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | years | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>450.0</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>June 29, 1957</u> , to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-25-57</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>C.P. Ryland</u> | | DATE SIGNED <u>4400 - 49th ST. NW Wash. 16, D.C. 5-25-57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>5-29-57</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>5-29-57</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> | |
| REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | ADDRESS <u>Hag. Md.</u> | |

CERTIFICATE OF DEATH

Reg. Gen. No.

1. Name of deceased

2. Date of death

3. Place of death

4. Age

5. Sex

6. Cause of death

7. Date of death

8. Place of death

9. Date of death

10. Place of death

11. Date of death

12. Place of death

13. Sex

14. Age

15. Date of death

16. Place of death

17. Sex

18. Age

19. Date of death

20. Place of death

21. Sex

22. Date of death

23. Place of death

24. Date of death

25. Place of death

26. Date of death

27. Place of death

28. Date of death

29. Place of death

BUREAU T. S.

JUN 3 1957

RECEIVED

West Haven Cemetery

1957-57

Robert T. Rinaldi, M.D., M.P.H.

NOTIFICATION

1. Name of deceased
2. Date of death
3. Place of death
4. Age
5. Sex
6. Cause of death
7. Date of death
8. Place of death
9. Date of death
10. Place of death
11. Date of death
12. Place of death
13. Sex
14. Age
15. Date of death
16. Place of death
17. Sex
18. Age
19. Date of death
20. Place of death
21. Sex
22. Age
23. Date of death
24. Place of death
25. Date of death
26. Place of death
27. Date of death
28. Place of death
29. Date of death
30. Place of death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05445

Item 21 FilmG216 6-3-57 et

CERTIFICATE OF DEATH

05433
Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 725 University Boulevard, East | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Russell Middle Thomas Last Williams | | | | 4. DATE OF DEATH Month May Day 23 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 12, 1905 | |
| 9. AGE (In years lost birthday) 52 yrs. | | IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. | | IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leadman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Cable Repairing | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Thomas H. Williams | | | | 14. MOTHER'S MAIDEN NAME Bertha L. Earl | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unascertainable | | | |
| 17. INFORMANT The Medical Record | | | | Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) Myocardial infarction & ventricular aneurysm DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8 yrs INTERVAL BETWEEN ONSET AND DEATH 3 mos | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month May Day 15 Year 19 57 Hour 11:30 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 15 , 19 57 , to May 23 , 19 57 , that I last saw the deceased alive on May 23 , 19 57 , and that death occurred at 11:30 p. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 5/24/57 | | | | | | | |
| ACTUAL SIGNATURE Emery C. Herman, Jr. M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) E Emery C. Herman, Jr. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 5/27/57 | | 22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C. | | | | | | | |
| DATE MAY 21 1957 REGISTRAR'S SIGNATURE Bessie Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

MAY 27 1957

RECEIVED

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05434

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 73 Days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 13121 Grenoble Drive | | | |
| 3. NAME OF DECEASED (Type or print) First David Middle Thomas Last WIMBERLY | | | | 4. DATE OF DEATH Month May Day 5 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 26 Oct. 1956 | |
| 9. AGE (In years last birthday) yrs. 6 | | IF UNDER 1 YEAR Months 9 | | IF UNDER 24 HRS. Hours 9 Min. 15 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Albert Wimberly | | | | 14. MOTHER'S MAIDEN NAME Mescal Bradfield | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mother, Mescal Wimberly (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia, bilateral 752 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal hydrocephalus, severe DUE TO (c) 6 mos. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21 Feb. , 19 57 , to 5 May , 19 57 , that I last saw the deceased alive on 5 May , 19 57 , and that death occurred at 11:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED XXXXXX | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar M.D. | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. 5-6-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-8-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey ADDRESS 7557 Wisconsin Ave., Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5-6-57 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parselly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051302 XV3

05309

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Elizabeth</u> Last <u>Witzke</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Caucas.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-11-80</u> | |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> | | IF UNDER 24 HRS. Hours <u>11</u> Min. <u>57</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Nebraska</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Jacob Hardt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Pauly</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Chart</u> Address <u>W. S. H.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ac. coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Obesity</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>yes</u> <u>yes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Fatigue</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1945</u> , 19 <u>May 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>57</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Chas H. Wolohon</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>500 Underwood St. N.W. DC</u> DATE SIGNED <u>5/6/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>May 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <u>CLINTON, MO</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Staller</u> ADDRESS <u>1245 12th St. N.W.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5/9/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Walter Staller</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 10 1957

RECEIVED

Handwritten signatures and notes at the bottom of the page, including a date "MAY 10 1957" and a signature.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

05447

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05436

Reg. Dist. No. 2/6

| | | | |
|--|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 6 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp. | | d. STREET ADDRESS Estworthy Rd. | |
| 3. NAME OF DECEASED (Type or print) William Eber Woodruff | | 4. DATE OF DEATH 5/2/57 Month Day Year 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/3/1908 |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Lakewood, Ohio | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME EBER Blaine Woodruff | | 14. MOTHER'S MAIDEN NAME Helen Herron | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 578-14-0583 | |
| 17. INFORMANT Hosp. Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive, Secondary Pleural hemorrhage (3500 cc.) DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Auto Accident DUE TO Auto Accident (b) Crushed Chest (c) Auto Accident | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured left leg & cerebral confusion | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in auto accident | |
| 20c. TIME OF INJURY Month, Day, Year 10:30 P. M. 4/25/57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) Potomac (County) Montg. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 5-6-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) Suitland (State) Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Samuels | | 24a. REC'D BY REGISTRAR 5-7-57 | |
| ADDRESS 1756 Pennsylvania Ave NW, Washington, DC | | 24b. REGISTRAR'S SIGNATURE Bernie M. Thompson | |

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05448

CERTIFICATE OF DEATH

05437 216
Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Chevy Chase</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5504 Grove St.</u> | | | | d. STREET ADDRESS <u>5504 Grove St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Warren</u> Last <u>Wright</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 22, 1899</u> | |
| 9. AGE (In years last birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>57</u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>James V. Wright</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Malessa McCarty</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>5504 Grove St. C.C. Md.</u> | | 17. INFORMANT <u>Mary H. Wright</u> | | Address <u>5504 Grove St. C.C. Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 YRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>April 15, 1957</u> , to <u>May 5, 1957</u> , that I last saw the deceased alive on <u>April 24, 1957</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Sidney Cousins</u> M.D. <u>3921 - Englewood St. NW</u> | | | | DATE SIGNED <u>5/3/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u> | | | | | | | |
| 22a. BURIAL CREMATION <u>Burial</u> | | 22b. DATE THEREOF <u>5/8/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>8 MAY 8 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------|--|-----------------------------|--|------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | |
| 4. Date of Death | | 5. Place of Death | | 6. Cause of Death | |
| 7. Date of Burial | | 8. Place of Burial | | 9. Name of Minister | |
| 10. Name of Physician | | 11. Name of Undertaker | | 12. Name of Coroner | |
| 13. Name of Registrar | | 14. Name of Health Officer | | 15. Name of Medical Examiner | |
| 16. Name of Nurse | | 17. Name of Assistant Nurse | | 18. Name of Hospital | |
| 19. Name of City | | 20. Name of County | | 21. Name of State | |
| 22. Name of Country | | 23. Name of Continent | | 24. Name of Hemisphere | |
| 25. Name of Ocean | | 26. Name of Sea | | 27. Name of Bay | |
| 28. Name of Strait | | 29. Name of Canal | | 30. Name of River | |
| 31. Name of Lake | | 32. Name of Pond | | 33. Name of Stream | |
| 34. Name of Creek | | 35. Name of Brook | | 36. Name of Run | |
| 37. Name of Branch | | 38. Name of Tributary | | 39. Name of Confluence | |
| 40. Name of Mouth | | 41. Name of Delta | | 42. Name of Estuary | |
| 43. Name of Bay | | 44. Name of Sound | | 45. Name of Fjord | |
| 46. Name of Strait | | 47. Name of Canal | | 48. Name of River | |
| 49. Name of Lake | | 50. Name of Pond | | 51. Name of Stream | |
| 52. Name of Creek | | 53. Name of Brook | | 54. Name of Run | |
| 55. Name of Branch | | 56. Name of Tributary | | 57. Name of Confluence | |
| 58. Name of Mouth | | 59. Name of Delta | | 60. Name of Estuary | |
| 61. Name of Bay | | 62. Name of Sound | | 63. Name of Fjord | |
| 64. Name of Strait | | 65. Name of Canal | | 66. Name of River | |
| 67. Name of Lake | | 68. Name of Pond | | 69. Name of Stream | |
| 70. Name of Creek | | 71. Name of Brook | | 72. Name of Run | |
| 73. Name of Branch | | 74. Name of Tributary | | 75. Name of Confluence | |
| 76. Name of Mouth | | 77. Name of Delta | | 78. Name of Estuary | |
| 79. Name of Bay | | 80. Name of Sound | | 81. Name of Fjord | |
| 82. Name of Strait | | 83. Name of Canal | | 84. Name of River | |
| 85. Name of Lake | | 86. Name of Pond | | 87. Name of Stream | |
| 88. Name of Creek | | 89. Name of Brook | | 90. Name of Run | |
| 91. Name of Branch | | 92. Name of Tributary | | 93. Name of Confluence | |
| 94. Name of Mouth | | 95. Name of Delta | | 96. Name of Estuary | |
| 97. Name of Bay | | 98. Name of Sound | | 99. Name of Fjord | |
| 100. Name of Strait | | 101. Name of Canal | | 102. Name of River | |

RECEIVED
MAY 8 1957
BUREAU V. 2

THE S. H. HARRIS CO. SPOILS OF WAR
BALTIMORE, MD
1000 N. E. ST.
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05449

CERTIFICATE OF DEATH

05438

Reg. Dist. No. 216

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN 1b <u>8 DAYS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>56</u> | | d. STREET ADDRESS <u>9302 SUTTON PLACE</u> 1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>WOOTTON</u> First <u>STEVEN</u> Middle <u>ELDRIDGE</u> Last <u>YOUNG</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-23-1874</u> |
| 9. AGE (In years lost birthday) <u>82</u> yrs. | | 10. UNDER 1 YEAR Months Days Hours Min. | 11. UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed now -</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE TOBACCO</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>DALLAS YOUNG</u> | | 14. MOTHER'S MAIDEN NAME <u>CAROLINE E. ECHISON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> | | 16. SOCIAL SECURITY NO. <u>577-10-5191</u> | |
| 17. INFORMANT <u>MR. EUGENE YOUNG (SON)</u> | | Address <u>4300 SUTTON PLACE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 26, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>9 45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D. | | ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>9/24/57</u> | |
| PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u> | | <u>Silver Spring, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5/29/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CATH. CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> | | ADDRESS <u>Silver Spring, Md</u> REC'D BY REGISTRAR <u>DATE 5-29-57</u> REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

BUREAU V. I.

JUN 3 1957

RECEIVED